Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or

Physician

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

filed within 72 hours after death with the

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Inc. M.

and burial-tra

attending physician for use as the burial

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After

after death Director:

24 hours a

To the within 2

WJL

completely filled in by the funeral

Maryland 21215-0036

Baltimore,

/Medical

Examiner Carroll Hospice Dove House 5. Social Security Number **Funeral** Director <u>160-16-</u>3047 Usual Residence of Decedent 10a. State Director Maryland 10e. Street and Number Funeral 208 Bell Road 11. Marital Status 1 Never Married 2 Married Completed by 3X Widowed 4 ☐ Divorced Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be ပ George A. Garrison 19a. Informant's Name/Relationship (Type. Print) <u>Jean Santamaria</u> 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Funeral Ser Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 D 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No Certification: To 27. Manner of Death 1'Natural 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c, License number 3/15/09 15552 M.P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Streat Wasminster, md m.D. 555 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

09-07027 Cath Med

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erine Gnage	-	1- For State	Sta	te of Maryland		rtment of <i>tificate</i> of		nd Men	tal Hy		No	000 0150
Physicia	ın/	Registrar 1. Decedent's Nam	ne (First, Middle,	Last)					- 1	2. Date of Death	No. Sear	3. Time of Death
lical Exami	ner	4a Facility Name (Mary Ca	therine Gn give street and numbe	agey	12	b. City, Town,	or Location (of Death	Month September	8, 2009 4c. County of D	1716 hrs
The second second			Hospital Cer)		Randalisto		Ji Doda		Baltimore (
Funeral Director		5. Social Security 1 215-22-2		7. A	ge (In yrs. la 84	ast birthday) Yrs.	If Under 1 Ye Months Da		er 24Hrs. Min.	8. Date of Birth	` le	Birthplace (State or oreign Country) MD
any	-	Usual Residence of	of Decedent 10b. County		10c. City,	Town or Locati	on					10d. Inside City Limits
* .	F	MD	Balti	.more		Balti	more					1 Yes 2 No
e Maryland or 28a-f show fied at once.	Director	10e. Street and Nu		.a			10f. Zip Code			100	. Citizen of What	Country?
eath with the Maryland items 13a or 28a-f sho ust be notified at once.		11. Marital Status	idge Roa	12. Was Decede	nt Ever in II	S 13 Wa	212		nin? (Sne	ecify Yes or No-	USA	American Indian, Black,
leath w r items	Funeral		ied 2 X Mar	ried Armed Forces			es, specify Cub				White, e	
s after ral", o	by F	3 Widowed		ced If Yes, Give Yeer or Dates:			Yes 2 X I			odi dono	Specify:	White
136 thin 72 hours aftere. than "natural", edical Examingr	eted	15. Decedent's E		fy only highest grade co		during m	ost of working li	ife. DO NOT	use retire	ed)	16b. Killa di Basili	less/illuusti y
vithin 7	Completed			2		Re	gistere					h Care
11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. narked other than "natural", or items 13a or 28a-f she event, the Medical Examiner must be notified at once	οl	17. Father's Name		.ast) Connell						(First, Middle, M erine La		
212 nould be id Ment is mark tic ever	To B	19a. Informant's N					,				er, City or Town,	State, Zip Code)
and 2 sl and 2 sl ealth ar em 27 rrauma		Mr. GLO		agey (Spou		2836	Ridge R	oad Ba	altin T	nore, MD	21244 20c. Location - C	ity or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical E		1 XBurial 2				crematory or othice View		ark	9/12	2/2009	Sykesvi	lle. MD
altin rmit. P spartme portar jury or		Donation 5 Signature of Fig.	Other Spe uneral Service L	icensee	1							
Physician	Ш	23a Part I Enter t	the disease or o	omplications that cause	00764	PO Do not enter t	Box 19	5 Syke	esvil	1e, MD	21784 st, shock, or heart	Approximate Interval
/Medical		21. Signature of Funeral Service Ucensee What Grant Home and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a Complications of Recurrent Gastointestinal Hemorrhage Associated with Hemicolectomy									between Onset and	
∀xaminer		or condition result		Due to (or as a cor								
	ner	Sequentially list of if any, leading to it	mmediate	Due to (or as a cor	sequence o	f):				-		
	Examiner	cause. Enter Und (Disease or Injury events resulting in	that initiated	Due to (or as a cor	sequence o	f):						
obe executed by sician and burial - transit				d	.					· -		
60, tte be ex hysician e burial	Nedical	UNPENDE	<u> </u>	AMENDED 23c. If yes, outc	ome of pred	nancy					23d. Date of de	elivery
ox 6876 eath certificate attending phy for use as the l	ician/M	23b. Was deceden past 12 month		1 Live birth	at time of de	2 Fe	etal death	3 Ectop	ic pregna	ncy	Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physic	1 Yes 2	No 9 Unkr			5 Ot	ther (Specify)					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	by PI	Part II. Other sign Hypertens		ons contributing to de	ath but not r	esulting in the	underlying caus	e given in P	art I.		2 V No 3	robably 4 Unknown
ords, I w requires is been sig should be	eted	Tiypertens				-				24a. Was a	n 24b. We	ere autopsy findings available
ecor he law r ite has b ige 2 sh	Completed									autops perfor		or to completion of cause of ath? Yes 2 No
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Physic er this	To	1 ✓ Yes 27. Manner of Dea	2 No		tient 2	ER/Outpatient		Other			Residence 6 ow injury occurred	Other:
ion c tending eath. or: Aft the func	tion	1 V Natural	5 Pendi		y,Yeer)		· · _	Yes 2	_			
ivisi or At after d Direct	Certification:	2 Accident 3 Suicide 4 Homicide		not be	Injury - At h	ome, farm, stre	et, factory, offic	e building, e	etc.	28f. Location (S or Town, St		or Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 2	Certifying Phy Medical Exam	ysician: To the best of niner:On the basis of earth manner state	xamination a	lge, death occu and/or investiga	rred at the time ition, in my opir	, date and p lion, death o	lace, and occurred a	due to the cause it the time, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)
in	ž	29b. Signature an	d title of certifier	1 1	100			ense numbe C.M.E.	r		29d. Date signed September 9	d (Month, Day, Year) 9. 2009
MJO		30. Name and add	dress of person	Sumely who completed cause of	f death (Iten	n 23a)		J.141. E.			20,000	
		Melissa Br	assell, MD	Assistant Medic	al Exami	ner 111 F	Penn Street	, Baltimo	re, MD	21201		
St Regis	ate trar	31. Date filed (Mo.	SEP 1 1	2009 32. Regis	trar's Signat	ure A.	arkal					
HMH 17 Rev 1/2						ORIGINA	tŁ.			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 13, 2009 12:43pm^M Sept. John Arthur Gotschall 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Carroll Hospital Center Westminster Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept 26, 1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Min. Hours 1 □XM 2 □ F 80 216-20-2525 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2X No Finksburg Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 USA 2996 Kenshaw Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWI 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify Specify. White WWII 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Asphalt Contractor Plant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Skelley Glen Dexter Gotschall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2996 Kenshaw Drive, Frinksburg, MD 21048 Mrs. Patsy Gotschall (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State All County Cremation | 9/14/2009 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses FUNERAL HOME & CHAPEL, P.A. MO0764 195 Sykesville, MD 21784 PO Box 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final remore no 0 disease or condition resulting in death) Due to (or as a consequence of) add Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 27 No 1 ☐ Yes 2 ☐ No 1 □Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed

signed by the a

certificate has been s rector, page 2 should

this certific al director,

After this funeral c

n 24 hours after death.

Re Funeral Director: Aft

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Be Completed by

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

2

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours affer death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner rest by ruffined at once.

Baltimore, Maryland 21215-0036

the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit attending physician for use as the buria Physician/Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No 27, Manner of Death

5 ☐ Pending investigation

6 □Could not be determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number

29b. Signature and title of dertifier

Randi Bramen, Do

29d. Date signed (Month, Day, Year)

Hame and address of person who completed cause of death (Item 23a) (Type, Print) aman 90

32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP18

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	State of Maryland / Department of Health and Certificate of Death	ı Men		. No.		8150
Physicia /Medica	n	1. Decedent's Name (First, Middle, Last) Remedios N. Torres Garcia	N	ate of Death Month	Day	Year 2009	3. Time of Death 5:10 A M
Examine Funeral Director	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De Holy Cross Hospital 5. Social Security Number 6. Sex 1 \square M 2 \boxtimes F 7. Age (In yrs. last birthday) Il Under 1 Year Il Under 24 H Months Days Hours Miles Miles	rs. 8, D	ate of Birth Mo <i>nth, Day,</i> \	Montg	Cour	lace (State or Foreign itry) ippines
Ö	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				12.00	0d. Inside City Limits 1 ▼Yes 2 □ No
ith the Ma or 28a-f	Sirec	Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code		109	g. Citizen of	f What Cour	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. If Heath and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinal must be notified at	by Funeral	217 N. Adam Street 20850	(Specify erto Ricar		14. Ra Bl	State: ace-Americ ack, White, ify:Fili	ean Indian, etc.
d within 72 hours aft glene er than "natural", or ; the "seccal Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Countant	vorking			Business/In	
d 2 should be filed v th and Mental Hygis 27 Is marked other traumatic event, it	To Be Co	17. Father's Name (First, Middle, Last) Unobtainable Unobta		st, Middle, Ma			
and 2 shoul ealth and M n 27 Is marl ner traumatl	-	19a. Informant's Name/Relationship (Type. Print) Manuel Garcia/Spouse 19b. Mailing Address (Street and Number or 217 N. Adam Street;	Rural Ro	ute Number,	•		Code)
e = 5		20a. Method of Disposition 1 Burial 2 Il Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory 9,	Date /18/0)9 B1	c. Location	a - City or To	own, State
permit. Pag Department Important: I any Injury o once.		21. Signeture of Funeral Service Licensee 22. Name and Address of Facility S 1040 Rockville Pi	ke; l	Rockvi	11e, 1	MD 208	
ificate be executed Hydrogram and physician and stree burial-transit as the burial-tran	edical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, dinear tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in right) that initiated events resulting in death) Last Lun: cancer Due to (or as a consequence of):	diac or res	piratory arres	st,		Approximate interval Between Onset and Death 1 yr
the death certifica y the attending phi ched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 5 □ Other (specify)				Date of deliv	ery Day Year
quires that in signed b	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary embolus, deep vein thrombosis, cigarette	_		acco use co		he cause of death? bably 4 ☐ Unknow
n: The law re licate has bee r, page 2 sho	Completed	smoking, hypertension			ed?	b. Were auto prior to co death? 1 □Yes	opsy findings available impletion of cause of 2 No
hysi this c	Certification: To Be	examiner? 1 Yes 2 Ho Hospital: 1 Hospital: 2 ER/Outpatient 3 DCA Other: 4 Nursin 27. Manner of Death 1 Mantural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) M 1 Yes 2 No	ing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			fy) al Route Number,	
spital or A		4 Homicide determined 299. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	lace, and	City or Town, due to the ca	State) use(s) and	manner as	stated.
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated. 29b. Signature and title of certifier 29c. License number	occurred a	t the time, da	te and plac	e, and due i	to the cause(s)
3		Barbaro Suparich F8M MD D006548 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5		9-1	0-0	9
Stat Registra		Barbara Supanich M.D. 1500 Forest Glen Road; Silve 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature	er Sp	ring,	MD 20	910	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6:08_{pм} **Physician** September 6, 2009 Margaret Marie Gibson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Chester River Hospital Chestertown, MD. Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F Yrs. 10-17-1950 Maryland 215-58-6092 58 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he ansisted once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Director Md. Centreville Queen Annes 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 304 Queen Anne Cir., Apt.D 21617 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: Black þ 3 ☐ Widowed 4 🔀 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Hynson Bertha James Mae Demby Leon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5701 Church Hill Rd., Chestertown, Md. 21620 Terry B. Gibson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 ☐Removal from State Price, MD. Rossevelt Cem. 09-12-09 4 Donation 5 Other (Specify) 21. Signature of Funeral Service b 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover St., Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ory Throw 2/08 D. Darub Orice Chirle, MD 3/6/9 32. Registrar's Signature

and manner stated.

Deneur B.

(Check only

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death

3. Time of Death

18:30

9. Birthplace (State or Foreign

Worcester. Mass

10d. Inside City Limits

1 □ Yes 2 XXO

11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Cerebrovascular Accident

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> Due to (or as a consequence of) Athenoscienotic Cardiovascular ditease Due to (or as a consequence of)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Hloknown

23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death

moo257

4☐Pregnant at time of death 9□Unknown

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Day

3 Probably 4 Munknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sub Endocardial Myorardial infusction Heart Failure

Congeshive tibrillo Hon Atricel

24a Was an autopsy
performed?

1 Yes 2 No

26. Place of Death (Check only one)

GYAN-C. SURANA

1 🗌 Yes

28d. Describe how injury occurred

Reg. No.

^{Day}2009

^{Year)} 1920

4c. County of Death

Calvert

10a. Citizen of What Country?

United States

16b. Kind of Business/Industry

Dept of Navy

Cheltenham, MD

14. Race - American Indian,

White

Black, White, etc.

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural

5 Pending investigation 6 Could not be

determined

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ☐ ER/Outpatient 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? М

3∏ DOA

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

-ona

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D 50653 29d. Date signed (Month, Day, Year) 9-16-2009

3368

To the Hospital or Attending Physician:

death.

after death

within 24 hours a To the Funeral I

Physician /Medical

Examiner

attending physician and for use as the burial-transit

detached

certificate has page 2

this

funeral director,

Division or Vital Records, P.O. Box 68760,

Examine

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

Registrar

Deale 585 31. Date filed (Month

Churchton 32. Registrar's Signature

DHMH 17 Rev 1/2001

Road. Deale

23e. Did tobacco use contribute to the cause of death?

2 No

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Harold Francis Hutchinson, Jr. Physician/ Month tembe :15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memoria astor Tallo-If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 29, 1915 1 **X** M 2 □ F Months Hours New York Director 130-07-9359 94 Usual Residence of Decedent or 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director any injury or other traumatic event, the Medical Examiner must be notified MD Talbot Easton 1 Tes 2 No 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code 23a Funeral 520 Trippe Avenue 21601 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force ō þ 1 Never Married 2 X Married Yes ガルギントルシのハ,什ぜのし Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes, Give Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Boat/Marine 8 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harold F. Hutchinson Margaret Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Elizabeth Hutchinson/wife 520 Trippe Avenue, Easton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation 09/14/2009 Stevensville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A. Ostnowski Joseph C 200 South Harrison Street, Easton, MD nter the mode of dving, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode o Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner wicho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events NNONIC Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown the 9 Unknown Division of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 26d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2195. Washington RK6

State Registrar

3altimore, Maryland 21215-0036 HOWROLL

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 5: 05AM 2009 Janet Watkins Hayman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Salis DU C the Lake Wicomico HOSPICE CZ) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth **Funeral** Days Year) 1 M 2 F Months Hours 75 220-26-9036 Director January 4, 1934 Maryland Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantual trained by motified a sonce. MD Director Wicomico Salisbury 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Price Road 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ≥ ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth Caregiver Holly Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Garfield Dashiell Erma Hitch ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Thomas Hayman/Husband 804 Price Road - Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens 09/19/2009 Hebron, Maryland e of Funeral Service License 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel- 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cause on each Immediate Cause (Final **Physician** LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to for as a parseguence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) the detached cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 Yes 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: 4 Nursing Home 5 Residence Other (Specify) HOSPI 3 Medical Certification: To 1∐ Yes After this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation I hours after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO058410 9/15/09 6 MA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARE Po 130 X 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State SEP 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	Ce	rtificate of Death	Reg.		3, Time of Death						
Physicia	an	1. Decedent's Name (First, Middle, Last)	- T		Month Sept. 13	Day 2009 Year							
/Medic	al	Herman Hargi 4a. Facility Name (If not institution, give street and number)	s, Jr.	4b. City, Town, or Location of Death		4c. County of Dea							
Examin	er	527 Alabama Avenue, Apt.19		Salisbury		Wicomio	co						
Funeral		 Social Security Number Sex Ag 	e (In yrs. last birthday)		8. Date of Birth (Month, Day, Y	9. Bi	rthplace (State or Foreign Country)						
Director		230-34-6894 1□M 2□F	77 Yrs.	World Bays Hours William	April 15,	1932 V:	irginia						
natural", or items 23a or 28a-f show	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits 1 ¥ Yes 2 □ No						
Ba-f s	Director	MD Wicomico	Sa]	lisbury	100	. Citizen of What C							
or 2	Dir	10e. Street and Number	0	10f. Zip Code 21801	109	USA	ountry :						
s 238	eral	527 Alabama Avenue, Apt.]			pecify Yes or No-	14. Race - Am	nerican Indian,						
to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it we Modical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ₺ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 ₺ If Yes, Give Year or Dates:	No Proceedings of the Process of the	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, Wh	ite, etc. lack						
tural E E	ed k	15. Decedent's Education	16a. Dece	edent's Usual Occupation	16	b. Kind of Busines							
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r tha	Completed	Elementary/Secondary (0-12) College (1-4or 9)	Ca	aretaker		Mamie Woo	odcock						
othe	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Ma	iden Surname)	_						
Menta rrked itic e	2	Herman Hargis, Sr.		Rose			Unk						
n and Mental Hygie is marked other t raumatic event, th	1	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ling Address (Street and Number or Ruuitland, MD 21826									
Health		Sharon Holbrook/Friend	P.0	O. Box 649- 301 Ha	Date 20	Salisbu	ry, MD 21804						
nent of H ant: If Iter ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		position (Name of ematory or other place)		,							
tant:		4 ☐ Donation 5 ☐ Other (Specify)			1/2009	Salisbu							
Department of Important: If It any Injury or conce.		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Salisbury, MD 21801											
0 E 8 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line.											
	8 1		ne.	inter the mode of dying, such as cardia	or respiratory arroc	, t.,	Interval Between Onset and Death						
ysician		Immediate Cause (Final disease or condition a. ASCV)											
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physician and the burial-transit													
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attending l	Physician/M	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant	of pregnancy 2 Petal death 3	3 ☐ Ectopic pregnancy		23d. Date of							
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been signed by the should be detached	hys	9 Ll Unknown			OO- Did tob	tobacco use contribute to the cause of death							
gned oe de	by F	Part II. Other significant conditions contributing to death	out not resulting in the	underlying cause given in Part I.			Probably 4 Unknow						
sen si ould t					1 1 705								
S 01	Completed				24a. Was an autopsy	prior	autopsy findings available to completion of cause of						
ate	E O				perform 1 ☐ Yes 2	ed? death							
ertific ctor,	Be (25. Was case referred to medical examiner?			ath (Check only one)							
his co	은	1 Yes 2 No Hospital: 1 □ Inpat	ient 2 ER/Outpat		Home 5 Resider		Specify)						
offer t		27. Manner of Death 28a. Date of In 1 ☑Natural 5 ☐ Pending (Month, D	ury 28b. Time ay, Year) Injury	y Work?	28d. Describe how	v injury occurred							
or: A	cati	2 Accident investigation		M 1 □Yes 2 □No	204 Location (Cts	eet and Number a	r Rural Route Number,						
irect in by	Certification:		ijury - At home, farm, s tc. <i>(Specify)</i>	street, ractory, office	City or Town,		Huras Houte Number,						
illed i		29a. Certifier Certifying Physician: To the bes	t of my knowledge, de	eath accurred at the time, date and place	e and due to the ca	use(s) and manne	er as stated.						
Fune Fune	Medical	29a. Certifier (Check only one) Certifying Physician: To the best one) and manner and manner one one of the basis	of examination and/or	r investigation, in my opinion, death occ	curred at the time, da	ite and place, and	due to the cause(s)						
within 24 hours area toegu. To the Funeral Director: After this certifical completely filled in by the funeral director, the funeral director director director, the funeral director director director, the funeral director d	Med	29b. Signature and title of certifier	nateu.	29c. License number	29	d. Date signed (M	onth, Day, Year)						
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me		30. Name and har ress of person who completed cause of	death (Item 23a) (Tyn	- Palan									
)		30. Name and accress of person who completed cause of YOGESH VOLKA 614 EV	STERN	parker of SALI	Sbuly, +	10, 21804							
		1 4 5 36											
St	ate	31. Date filed (Month, Day, Year) 32. Fegis	trar's Signature	1									

			Please Type or Print in Black Inc		-	-
		,	1 - For State of Maryland / Department	rtment of Health and M tificate of Death	, ,	iene ^{9g. No.} 2009 315 11
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Jeffrey Scott Harmon		2. Date of Death Month Sept.	Day Year 3. Time of Death 11, 2009 3:00p ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			931 Century Street	Hampstead		Carroll
ı	Funeral Director		5. Social Security Number 212-78-0196 Usual Residence of Decedent 6. Sex 17. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 3 / 1 1 / 1	Year) 9 6 0 9. Birthplace (State or Foreign Country) MD •
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Loc MD. Carroll Hampste			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 931 Century Street	10f. Zip Code 2 1 0 7 4	10	0g. Citizen of What Country?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evarinter must be notified at		Armed Forces? If	Vas Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto ☐Yes 2♥ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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Maryland 2	12 should be filed within th and Mental Hygiene. 7 Is marked other than traumatic event, the Me	To Be Co	12 OVERN 17. Father's Name (First, Middle, Last) Donald R. Harmon	18. Mother's Name Margare	(First, Middle, N	flaiden Surname)
_	1 and 2 shot Health and N tem 27 is ma		7	g Address (Street and Number or Rura Century Street		City or Town, State, Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1	sition (Name of latory or other place) Cremation 9/14		20c. Location - City or Town, State Hampstead, Md.
Balt	permit. Departi Import any inj once.			Name and Address of Facility El: 34 S. Main St.	ine Fun Hamps	neral Home stead, Md. 21074
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac of the Nead	or respiratory arre	Approximate Interval Between Onset and Death
60,	be executed ician and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):			
P.O. Box 6	The law requires that the death certificate bate has been signed by the attending physic bage 2 should be detached for use as the base.	Physician/Medica		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that s been signed k should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tob	oacco use contribute to the cause of death? es 2 ⊒ No 3 □ Probably 4 □ Unknown
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Z.	Physician: The this certificate al director, pag	æ	25. Was case referred to medical exampler? 15. Was case referred to medical Hospital:	26. Place of Death	(Check only one	e)
of	Phys r this ral dii	<u>년</u>	1			ence 6 Other (Specify) ow injury occurred
Division	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifics nely filled in by the funeral director;	Certification:	1 □ Natural 5 □ Pending investigation 3 ☑ Suicide 6 □ Could not be determined 1 □ Natural 5 □ Pending investigation 6 □ Could not be determined 1 □ Suicide 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	Work? 1 □ Yes 2 ☑ No	Shot 5 28f. Location (St.	clfin head reet and Number or Rural Route Number,
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	To the within 2 To the comple	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month, Day, Year)
	Mar		30. Name and address of person who completed cause of death (Item 23a) (Type, I	000 5192U	5	Manchester Min 200
	Sta		Herbert P. Hen Jerson Jr. MD 2973 31. Date filed (Month, Day, Year) 32. Regeltrar's Signature SEP 14 2009 Denous A.	5 Manchester	KJ /	Manchell ermi
DHI	Registr		SEP 14 2009 Lenua B. A	Parks		

■ Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physici		1. Decedent's Nam	e (First, Middle, La	y C. Je	NSP	1			Mont	of Death	500	3. Ti	me of Death
/Medic Examin		Carroll	Hospital	street and number			4b. City, Town, o				4c. County of [200
Funeral Director		5. Social Security N 220-22-5 Usual Residence of	868	Gex 7. A(ge (In yrs. 82	last birthday Yrs.) If Under 1 Year Months Days	If Und Hours	er 24 Hrs. 8. Date Min. Aug	th. Dav. Yea	g. 1927	Birthplace (S Country)	State or Foreign
show	'n	10a. State	10b. County			y, Town or L							ide City Limits
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feath w	Funeral	1261 We	ller Way	12. Was Decedent	Ever in U.	S. 13.		.158 Hispanic (Origin? (Specify Yes	or No-	USA 14 Bace - A	American Indi	an
72 hours after death with the Maryland "natural", or items 23a or 28a-f show citical Evanity from the modified at	by		ied 2 Married 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No		If Yes, specity Cub 1 ☐ Yes 2 ☐ 💥 o	Speci	Origin? (Specify Yes can, Puerto Rican, et fy:	c.)		white, etc.	
4 75	Completed	(Spec	15. Decedent's Educify only highest grant	ducation ade completed) College (1-4or	5+)	(Give	edent's Usual Occuj e kind of work done DO NOT use retire	durina m	ost of working	16b.	Kind of Busine	ess/Industry	
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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ira IV once.			ame/Relationship (1	ing Address (Street		westmins				
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t. Page rtment rtant: If		4 Donation	5 ☐ Other (Specif		·	mpste	ad Cemete	ry	9/18/200		ampstea	. •	
permi Depar Impor any Ir		21. Signature of Fu	Ineral Service Licer	nsee		2	Pritts Fu 412 Washi	nera nato	T ^{ty} Home and n Road We	d Char estmir	el, P. ster, 1	A. MD 21	157
Physician /Medical		23a. Pa 1. Ent the shock, or head immediate Cause (disease or condition resulting in death)	rt failure. List only (Final	p cations that cause ne cause on each li a. Due to (or as	ine. Suv	Do not en					-	Approx	ximate al Between and Death
executed mand and ial-transit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unda Cause (Disease or that initiated events	nditions, mediate nying injury	b. Due to (or as	a consequ	ence of):	10 >					YRG	us ass
cate be exec		resulting in death) L	ast	Due to (or as	a consequ	ence of):						172	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 25 g ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a g ☐ Unknown	2 Fetal	death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	ey			23d. Date of Month	delivery Day	Year
equires that										e of death?			
n: The law re icate has be r, page 2 sh	Completed by	Mit	ral V	alve p	rol	apsi			24a.	Was an autopsy performed? (es 2	prior deat	to completion	
ysiciar is certif director	o Be	25. Was case referr examiner? 1 ☐ Yes 2		Hospital: 1 ☐ Inpatie	ent 2	B/Outpatie	nt 3 □ DOA Oth	or:	ce of Death (Check		6 □Other /	Pagaifu)	
ding Ph h. After th funeral	tion: T	27. Manner of Death 1 De Natural	5 Pending	28a. Date of Inju (Month, Da	ırv 🖅	28b. Time o Injury	f 28c. Injur Wor		28d. Desc		jury occurred	эреспу)	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification: To	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6 □ Could not be determined		ury - At hor c. (Specify	me, farm, str	reet, factory, office	Yes 2L	28f. Local	ion (Street or Town, Sta	and Number o. ate)	r Rural Route	Number,
ne Hospit n 24 hour ne Funera	Medical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examinat	vledge, deat ion and/or ir	h occurred at the ti ovestigation, in my o	me, date opinion, d	and place, and due teath occurred at the	o the cause time, date a	e(s) and manne and place, and	er as stated. due to the car	use(s)
MIT WITH WITH	Ž	29b. Signature and	title of certifier	No	VE		29c. Licens			29d. [Date signed (M	onth, Day, Ye	ar)
10		30. Name and addre	ess of person who	completed cause of d	leath (Item	23a) (Type, COL n	Print) Dr 1	Nes	1043 tminste	1	MD 2	211-7	
Stat Registra	٠	31. Date filed (Mont	0.77	32. Registr			backer		, , , , , , , , , , , , , , , , , , , ,				
HMH 17 Rev 1/20	01			2000 /00/0		1. 17							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar #20C, FH, TCHD, 9/13/07 1. Decedent's Name (First, Middle, Last) **Gertificate of Death** Reg. No. 2. Date of Death Month 9 **Physician** M. Jones 09 Shirley 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔭 F Months Days Hours Min. 213-70-9487 Director 09-11-1956 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location ral", or items 23a or 28a-f show Funeral Director MD. ambridge)orchester 10e. Street and Number 10g. Citizen of What Country? be filed within 72 hours after death with USA 818 Maces 21613 ane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Completed by Specify Specify: 3 Widowed 4 Divorced "natural" Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany Injury or other traumatic event, Ire Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Allen 12 Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Gilbert Lee Dennis Nettie mae Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William ORVILLE Jones Husband 818 Maces Lane, Cambridge, Md. 21613 20c. Location - City or Town, State Rhodesdale 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Vienna, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Keids Grove Cemetery 09-19-09 22. Name and Address of Facility, Bennie Smith Funeral Home 21. Signature of Funeral 9 vice Licensee 426 Dover Street, Easten, Maryland 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Disseminate Tuberculosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Castric Carcinoid Tumor burial-tran Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 M No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \sum No 1 🗹 Yes 1 ☐ Yes

or Attending Physician: The law requires that the death certificate be of Vital Records, this certificate funeral After Division ours after death.

neral Director; A death.

Be Certification: To Medical

To the Hospital or within 24 hours at To the Funeral D completely +3 State Registrar 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 14 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Decelius, MD 1336374321 Leena

September 09 2009

1 0 1

3. Time of Death

6: 29 PM

Birthplace (State or Foreign Country)

Black

Foods

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 🗆 No

Year

1 XYes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rafeena Bacchus 22 South Greene Street, Baltimore, MD 21201 MD

32. Registrar's Signature 31. Date filed (Month, Day, Year)

SEP 14 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 143009 Johnson David Bruce 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number Hours 1 **X** M 2 □ F 212-56-1788 Feb. 15, 1951 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Baltimore Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 U.S.A. East Northern PKwy. 7903 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Armed Forces:

1 Ness 2 No
If Yes, Give 11 14 70
Year or Dates: +0 2873 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Truck 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Handy David Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Drive, New Castle, Delaware 19720 Wanda Strick land-daughter 203 Ermine 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ₩ Burial 2 Cremation 3 Removal from State 9121109 Hurlock md Md. Veterans Cemeters 4 ☐ Donation 5 ☐ Other (Specify) Anthony E. Ward F. H. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 30639 Drincess Anne, melz 1853 Hampden Wark 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of): Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

ပ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exc. in the mitter must be maiffed at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical

Division of Vital Records, P.O. Box 68760,

ysician/iv	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month Day Year
d by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
omplete			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
e	25. Was case referred to medical	26, Place of Death (0	Check only one)
ດ 0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
ation:	27. Man of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work?	d. Describe how injury occurred
Certifica	3 ☐ Suicide 6 ☐ Could not be determined		f. Location (Street and Number or Rural Route Number, City or Town, State)
dical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-07126 Camille A. Jackson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physic	vian	1- For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Re	eg. No.	9 3 5
Medical Exam	nine		Date of Deat Month		3. Time of Death
		Camille A. Jackson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month Septembe		0345 hrs
(Southern Maryland Hospital Clinton		4c. County of Deat Prince George	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birt		thplace (State or Foreign
Directo	1	377-36-0699 1 M 2X F 66 Yrs. Months Days Hours Min.		0/1943 Co	ountry)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location	03/23	71743	DC
d e wow as	١.	Manual 1 Drain of College Processing			10d. Inside City Limits
arylan Sa-f sl	흥	10e. Street and Number			1 X Yes 2 No
he Ma or 22 ified 3	Director	10f. Zip Code	10	g. Citizen of What Cou	ntry?
with t	la E	512 Wilson Bridge 20745 11. Manital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Research Communication)		United Sta	
death r iten	Funeral	11. Martial Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Speins of the Specify Cuban, Mexican, Puerto R	cify Yes or No- tican, etc.)	14. Race - Amer White, etc.	can Indian, Black,
after al", o	by F	Wildowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No. specifiv:		Specify: No.	
hours natur Exam	g		rk done	16b. Kind of Business/I	gro
36 in 72 han " lical 1	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired	d)		,
-00. d with giene ther t	E	11th Home Care 17. Father's Name (First, Middle, Last)		Priva	ate
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Bec	John Tackson		aiden Surname)	
ould by mar	To	19a. Informant's Name/Relationship (Type, Print)			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Janice Redmond/ Sister 924-14th Street SE		0003	, Zip Code)
ore, slan of Hea If iter		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery	Date	20c. Location - City or	Town, State
Page Page nent cant			2009		
Salt ermit reparti mporti ijury	- l'i	Signature of Funeral Service Incens	art Fur	clinton,	Maryland
		I W 4001 Benning Rd. NF	' Wachi	inatan Da	20019
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arres	t, shock, or heart	Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a concessions of the content of			Between Onset and Death
		Due to (or as a consequence of): Sequentially list conditions, b			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of):			
	Eal	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
cuted		d.			
760, ficate be executed by physician and the burial - transit	Medical	UNPENDED AMENDED			
760, ficate be g physical the buri	We.	IF FEMALE: 23b. Was decedent pregnant in the		23d. Date of delivery	
ox 687 eath certificant attending for use as t	sician/	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy	/	Month Da	y Year
Box e death c the atten	ysi	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown			
cords, P.O. Box 68 aw requires that the death certif as been signed by the attending should be detached for use as	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
S, P.C	od by			2 No 3 Proba	
ords, w requir	Set		24a. Was an		ppsy findings available
Recol	Completed		autopsy performe	prior to co death?	mpletion of cause of
75	0 3	25. Was case referred to medical examiner? 26.Place of Death (Check only	1 Y Yes 2	No 1 Ves	2 No
Vit Physic this o	2	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 4 Nursing Ho		sidence 6 Other:	
n of ling Pl		27. Manner of Death	-	injury occurred	
Sion Vitence death ctor: vy the	Certification:	Pending Accident Investigation 1 Yes 2 No			
Divisospital or At hours after dineral Direct y filled in by	Ĭ	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f.	Location (Stre	et and Number or Rura	Route Number, City
sspi hou ner y fill		4 Homicide determined (Specify)	or Town, State	,	9
Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this cal	ر ا ش	(Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due	to the cause(s) and manner as stated	
To wit) Z	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated. 29b. Signature and title of certifier			
		29c. License number O.C.M.E.	l _	3d. Date signed (Month	,
3	3	30. Name and address of person who completed cause of death (Item 23a)	\	eptember 12, 200)9
OL		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			13
Sta	e 3	31. Date filed (Month, Day Year)			
Registr		SEP 2 1 2009 Janes B. Jake			
HMH 17 Rev 1/200	1	O DIOWAY			

OCME:2006:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 9 ^{Day} 5 **Physician** 2009 8:45AM E. Little Richard /Medical 4a. Facility Name (If not institution, give street and number) Dove House 4c. County of Death Carroll 4b. City, Town, or Location of Death Westminster Examiner 9. Birthplace (State or Foreign Country) MD 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 18, 1920 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 M 2 F 89 Director 217-12-2349 Usual Residence of Decedent carroll 10d. Inside City Limits 10c. City, Town or Location Westminster Oa State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 2514 Littlestown Pike 10f. Zip Code 21158 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status White, etc. White 72 hours after 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 11 Farming 18. Mother's Name (First, Middle, Maiden Surname Maude Schaeffer 17. Father's Name (First, Middle, Last) Carroll Little Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2514 Littlestown Pike Westminster, MD21158 Betty Little-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 09/1972009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinty Lutheran Cemetery Taneytown, MD 21. Signature of Funeral Service Licensee Little S FH 34 Maple Ave.Littlestown, PA Richard Little 17340 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2MNo 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes __2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient this funeral c 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director: After t Certification: 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

WJL

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-07467 Louis Ladas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

		1- For State Registrar		ate or iviaryi	and / L	epartme Certifica	ent of ate of	Health and <i>Death</i>	d Menta	al Hygiene		1	0 0 1 5
Physi Medical Exa	ciar min	1. Decedent's Namer Louis H								2. Date of D Month	Reg. No. eath Day	Voor	3. Time of Death
f .		4a. Facility Name (f not institutio	n, give street and nu	ımber)		41	o. City, Town, or	Location of	Septem	per 24, 20	Year 09 unty of Deat	1010 hrs
France		15301 Sprir						Germantow				tgomery	,,1
Funera Directo		5. Social Security N 199-70-4		6. Sex	7. Age (In	yrs. last birth	nday)	If Under 1 Year Months Days		Min		YYYY) 9. Bi Forei	rthplace (State or
		Usual Residence of		1 X M 2 F		20	Yrs.		110010	09/10	/1989	Co	puntry) PA
ow any		10a. State MD	10b. County			. City, Town o		n					10d. Inside City Limits
Maryland 28a-f show		10e. Street and Nur	Montgo	omery	D	arnest	own						1 Yes 2 No
the Man	Director	15301 Sp		adows Dri	ivo			10f. Zip Code			10g. Citizen	of What Cou	intry?
hours after death with the Maryland natural", or items 23a or 28a-f she	Funeral Director	11. Marital Status 1 X Never Marrie		12. Was Dec	edent Ever	r in U.S.	13. Was	20874 Decedent of Hisp	anic Origin	? (Specify Yes or N	United	Stat	es ican Indian, Black,
٠ <u>٠</u> ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ	: 1			1 Yes	2 X		If Yes	, specify Cuban,	Mexican, P	uerto Rican, etc.)		White, etc.	
ours af	1	12.5		or Dates: ify only highest grad		ed) 16a. D		es 2 X No Usual Occupation		d of work done		cify: Whi	
36 in 72 h han "n tical F	atelo	Elementary/Secon		College (1-		dı	uring mos	t of working life.	DO NOT us	e retired)	Tob. King	of Business/	industry
215-0036 be filed within 72 mal Hygiene. rked other than "	Completed	17. Father's Name (irst, Middle, I	2 Last)		S1	tudei		2.54.11		Co1	lege	
21215-0036 ould be filed within 7 Mental Hygiene. in marked other the Medica	B B	Harilaos	Elias	Ladas						lame (First, Middle Catherine			
Shoulk and M 7 is m	6	19a. Informant's Nar Mary Cath	ne/Relationsh		- 4-1-	19b.	Mailing A	daress (Street	and Numbe	r or Rural Route Nu	mber, City or	Town, State	, Zip Code)
Te, N 1 and 2 Health Fitem 2		20a. Method of Disp	osition		other	20b. Place of			eadows	B Drive D	arnest	own, l	MD 20874 Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	l,	1 X Burial 2 4 Donation 5	Other Soc	3 Removal fro	m State	cremator	y or other	place)			1		
Balt Departit Departit Import	d	21. Signature of Fun	eral Service L	icensee			22. IVali	ie and Address C	n raciiity	0/30/2009 Toseph Ga	wlerie	Sana	Tma
Physician		23a. Part I. Enfer the failure. List only	discase, or c	mplications that car	used the d	eath Do not a	1.7 1. 1 (1	WISCODE	יאר חדיב	MILT T7 -	_ 7		20016
/Medical		Immediate Cause (Fi	nal disease	n eact line. a. Asphyxi		odan. Do 110(6	enter the	node or dying, st	ich as cardi	ac or respiratory ar	rest, shock, o	r heart	Approximate Interval Between Onset and
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760, cate be execui physician and he burial - tra	Medical	X UNPENDED		AMENDED 2	3a,27	7,28a-	f,pei	mE, g89	8 12/	2/09 TT			
x 68760, h certificate be lending physici use as the buri		23b. Was decedent propast 12 months?	egnant in the	1 Live birt	ncome of p	regnancy	Fetal o		Ectopic pre		23d. Date Mont	e of delivery	ay Year
Box 687 he death certification of the attending hed for use as the	Physician	1 Yes 2 No	9 Unkno		nt at time o	f death 5	Other	(Specify)		,	,,,,,,,		ay real
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	by Pt	Part II. Other signific	ant condition	s contributing to d	leath but n	ot resulting in	the unde	rlying cause give	en in Part I.	23e. Did to	bacco use co	ontribute to t	he cause of death?
ords, F w requires is been sign should be													ably 4 🗸 Unknown
Records, P.O. The law requires that the instance of icate has been signed by page 2 should be detact.	Completed									24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
	ပ္မို	25. Was case referred	to medical							1 🗸 Yes	med? 2No	death? 1 ✓ Yes	2 No
of Vital ig Physician: ther this certifueral director,	10 B	examiner?	No	Hospital: 1 Inp	atient 2	ER/Outpa	atient 3	26.Place of DOA Oth	er 🗀		Residence (Other	Scono
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Division tal or Attendir safter death.	ficat	2 Accident	Investiga	ation Fd 9/2	4/09	FD 09	50 h	tory, office build	2 X No	over he	ad		
Divis Hospital or At 24 hours after d Funeral Direc	Certification	4 Homicide	Could no determin			idence		ctory, office build	ing, etc.	or Town, S Dr. Ger	ate) I 5 K(I	Snr	Route Number, City Ing Meadows
the the	ā	29a. Certifier 1 Ce (Check only 1 Me	tifying Physi	cian: To the best of	f my knowl	edge, death o	occurred a	it the time, date a	and place, a				l.
	Med	29b. Signature and title	order Examini	er: On the basis of e and manner state	ed.	andormves	sugation, i	n my opinion, de 29c. License nu	ath occurred	d at the time, date a	ind place, and	d due to the	cause(s)
2		1/1	1111		X		175	O.C.M.E		11	29d. Date si		
	3	30. Name and address	of person who				(/)	/			,		
Sta	ite 3	Russell Alexan		Assistant Med	lical Exa		-	nn Street, Ba	ltimore, I	MD 21201			
Registr	ar	JE	1 20	2009 32. 13	ماس	B. 14	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State State Registrar	•	tificate of D	eath	Re	g. No.	9116	315	1/
П	Olemaini		1. Decedent's Name (First, Middle, Last)				Date of Death Month	n Day	Year	3. Time of D	
	Physicia /Medic	al	VERA MAE LANE				Sept	10	2009	6:00	PM
3	Examin	er	4a. Facility Name (If not institution, give street and number)	1	4b. City, Town, or L	ocation of Death			inty of Death 'albot		
40			Genesis HealthCare - The F 5. Social Security Number 6. Sex 7. Age (In yrs.			If Under 24 Hrs.	8. Date of Birth		9. Birthr	lace (State or	Foreign
В	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ XF 7. Age (<i>In yrs.</i> 215-16-8177 85 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	(Month, Day, 09–27–1	Year)	Cour	ntry) MD	
	land wo			ty, Town or Loc	ation				1	0d. Inside City	
	Mary First	호	MD TALBOT		EASTON				1 ☐ Yes 2 No		
	h the	Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen	of What Cour	ntry?	
	th with	al D	201 FEDERAL ST. APT. 14			601			J.S.A.		
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	.S. 13. W	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Esarins, must be caffied at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		□Yes 2ᢂNo	Specify:			ecify: WHI		
رب ص	72 hd	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupat kind of work done du DO NOT use retired)	ıring most of worki		16b. Kind o	of Business/In	austry	
12	vithin sne. than '	d L	Elementary/Secondary (0-12) College (1-4or 5+)		OMEMAKER			OWN	HOME		
2	Hygie Hygie Ither I	ပိ	17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Name	(First, Middle, N	Maiden Sur	rname)		
au	d be fantal	o Be	GEORGE MILTON GREENWOOD			VIOLA VI	RGINIA J	JONES			
Maryland	should nd Ma mark mati	မ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street e	nd Number or Run	al Route Number	r, City or To	wn, State, Zi	p Code)	
<u>8</u>	alth al		HATTIE GRUBB / DAUGHTER	118 DE	ELAWARE DI	RIVE, NEW	CASTLE	. DE	19720		
<u>o</u>	S 1 al		20a. Method of Disposition 20b. I		sition (Name of natory or other place		Date	20c. Locat	ion - City or T	own, State	
Ë	Page sent o nt: If ry or		I 1 IXI Burial 2 I Cremation 3 I Hemoval from State		MEMORIAL I		-2009	EAST	ON, MD		
Baltimore,	permit. Departm Importal any inju		21. Signature of Funeral Service Licensee	म म	Name and Address ELLOWS, HE	ELFENBEIN	& NEWN	AM FU	NERALH	OME, P.	.A.
			23a. Part1: Enter the disease, of complications that caused the dear	th. Do not ente	er the mode of dying	, such as cardiac	or respiratory arr	est,	21001	Approximate Interval Bety	9
	Obvertales	8 9	nock, or heart failure. List only one cause on each line.	.)	. h	1 /100				Onset and D	Death
The state of the s	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consection)	quence of):	arl t	- Cura				Week	
	Examiner		14	ntie	cardo	Ve foul	ne. X	1520	50	year	11
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):		+ 11,100				/	
	cuted nd ransit	Examiner	that initiated events c.								
oʻ	e exe ian ar ırial-t		resulting in death) Last Due to (or as a consec	quence of):							
68760,	tificate be executed ig physician and as the burial-transit	/ledical	d								
<u> </u>	as as	Mec	IF FEMALE: 220 If you guiteeme of progra	anov.				000	. Data of doli		
Вох	death cer e attendin ed for use	Physician/	23b. Was decedent pregnant in the past 12 months?	al death 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>			230	I. Date of deli Month		Year
O.	D 0 D	ysic	1 Ye's 2 No 9 Unknown	deall 5L							
σ.	de de		Part II. Other significant conditions contributing to death but not re-	sulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use	contribute to	the cause of d	leath?
ds,	uires sign Id be	d by	chanic) sidney of	11-225	٦		1 □ Y	es 2 🗗	No 3□ Pro	obably 4 □ l	Unknown
Record	w requir been s	Completed	Dialistes Middle	Vue			24a. Was a	an 2	24b. Were au	topsy findings completion of c	available
Re	The law cate has page 2 s	E C	THE THE STATE OF T	Poli			autop: perfor 1 □ Yes	med?	death?	2 ☐ No	ause oi
Vital		ပိ	25. Was case referred to medical			26. Place of Deal			12100		
<u> </u>	S S	0 0	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatier	nt 3 DOA Othe	er: 4 Vursing H	ome 5 🗆 Resid	lence 6 [Other (Spec	cify)	
) of	ding Phys	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Injury Work	at ?	28d. Describe h	ow injury o	occurred		
<u>i</u>	Attending r death. ector: After by the fune	atio	2 Accident investigation		M 1□	Yes 2 □ No					
Division	after death after death Director: d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At 1 building, etc. (Special Could not be building, etc.)	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	Street and I vn, State)	Number or Ru	rai Route Num	ıber,
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	th occurred at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as lace, and due	s stated. to the cause(s	s)
	o the vithin : o the omple	Mec	29b. Signature and title of certifier		29c. License	e nu m ber		29d. Date	signed (Monti	h, Day, Year)	
	F 3 F 8		ish to w	1D	D2	5750		9/1	11/69		
7			30 Name and address of person who completed cause of death (Its		Print)		1	n^	10 0	1501	
_	2K3		ROBERT SANCHEZ MD 508	8 INLE	AT CHIM.	KNO K	FASTO	in, I'	11) 2	1601	
	St	ate	31. Date filed (Month, Day, Yeer) 4 2009 32. Fegistrar's Sign	nature.	backer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Month SEPTEMBER 16, 2009 **Physician** 16:15 CATHERINE LANCASTER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGES FORT WASHINGTON FORT WASHINGTON HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, Year) MARCH 20, 1936 7. Age (In yrs. last birthday) Social Security Number Funeral Days Months MARYLAND 1 □ M 2 😿 F 73 217-44-5025 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State id other than "natural", or items 23a or 28a-f show event, the Medical Evan than inst be notified at 1 ¥Yes 2 ☐ No Director PRINCE GEORGES OXON HILL MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 UNITED STATES 1202 DEVONSHIRE DRIVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XNo Specify Specify: ģ BLACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 6TH GRADE (0-12) College (1-4or 5+) FOOD SERVICE KITCHEN HELPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY LUCILLE LANCASTER DIXON RICHARD DENNIS SWANN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1202 DEVONSHIRE DRIVE, OXON HILL, MARYLAND 20745 NANCY L. LANCASTER / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART CHURCH CEMETERY SEPT. 22, 2009 LA PLATA, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. ure of Funeral Service Licenses L HOME, P.A. ROAD, INDIAN HEAD, MARYLAND 20640 TADIA C. THORNTON JOHNSON Approximate Interval Between Theet and Death 23a. Part 1. Enter the disease, or complications that caused the death. De-not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-Physician/Medical as the IF FEMALE nse yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day Por in the past 12 months? ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 2 No 1 Inpatient Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes ၉ 28c. Injury at Work? 27. Manner of Death 1 2 Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide

P.O. Box 68760. death certificate be

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed vent of Health and Mental Hygies ant: If item 27 is marked other the sourts of the states of the s

and

physician

the attending be detached signed by Division of Vital Records, page 2 should has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

BB2	,
	Sta

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMIR-MIRZA ALIKHAM - FORT WASHINGTON MEDICAL CENTER,

31. Date filed (Month, Day, Year) SEP 18 2009

29a. Certifier

29b. Signature and title of certifier

Medical

32. Registrar's Signature Back.

Registrar

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

FORT WASHINGTON, MARYLAND 20744

11711 LIVINGSTON ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 5:45A M 16 Robert Lathbury /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbur the Lake HOSPICE WICOMICO at Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Min 1 € M 2 ☐ F 55 June 26,1954 DE Director 222-38-4307 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 1 √Yes 2 No **Funeral Director** Worcester Bishopville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 12839 Old Stage Rd. 21813 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No Army
If Yes, Give
Year or Dates: 1 Never Married 22 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "y any lighty or other traumatic event, tre Med 90se. Elementary/Secondary (0-12) 12 College (1-4or 5+) Landscaping Equipment Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lathbury Ethel Mae Smith ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rebecca L. Lathbury/wife 12 839 Old Stage Rd., Bishopville, MD 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory9/17/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lawis 1. Watson Funeral Home
1618 West Rd., Salisbury, MD 2 21. Signature Juneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTB MYBLOID LRUKFAMIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☑ No 1 □Yes 2 □Nô 25. Was case referred to medical examiner? Be 26. Place of Death (Check only o e) Hospital: Other: 4 Nursing Home 5 Residence & Other (Specify) HCSPICA 1 | Yes 2 | 1 | Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation To the Hospitan -- within 24 hours after death.

To the Funeral Director: After a managed of the funeral by the funeral part of the funeral part o 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

NR

2mg

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ce Huysy

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

WAY

SED 1 R

PO

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32. Fegistrar's Signature

2 obert Lathbur

29c. License number

D0058410

SACIBLLY

29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day James John McMahon 0354 September 16 M 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Union Memorial Hospital 8. Date of Birth (Month, Day, Jan. 18, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Social Security Number . 1923 Min. Months Days Hours Illinois 347-14-6087 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 20905 701 Pebblestone Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No 14. Race - American Indian Black, White, etc. 12 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced WWIT 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dentistry Dentist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Girard John Lawrence McMahon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1810 High Point Road, Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type. Print) Karen Koch/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Sept. 18 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia

Physician /Medical

Department of Health an Important: If Item 27 Is any Injury or other trauonce.

Physician

/Medical

Examiner

10a. State

Directo

Funeral

Completed by

Be

ဥ

Funeral

Director

of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Examinational be notified at

with

death

Pages 1 and 2 should be filed within 72 hours after

Saltimore, Maryland 21215-0036

Examiner

Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran and attending physician for use as the buria

Immediate Cause (Final disease or condition resulting in death)

in the past 12 months?

1 ☐ Yes 2 ☐ No

21. Signature of Funeral Service Licensee

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Respiratory 2 hours Failure Due to (or as a consequence of): Due to (or s a consequence of) 2 months Intraabdominal Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year

Francis J. Collins Funeral Home Inc.

500 University Blvd. W., Silver Spring, MD 20901

29d. Date signed (Month, Day, Year)

AT 2438946 B35 | September 16.2009

Physician/Medical Examiner IF FEMALE 23b. Was decedent pregnant δ Completed Be 25 Certification: To 27 Medical

a Chkuowu			
rt II. Other significant conditions co	ontributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown
examiner?		24a. Was an autopsy performed? 1 \[\text{Yes} \] 2 \[\text{No} \] No \[24b. Were autopsy findings available prior to completion of cause of death?} \]	
		26. Place of Death (C	heck only one)
	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	5 Residence 6 Other (Specify)	
1 Natural 5 □ Pending	(Month, Day, Year) Injury	Work?	. Describe how injury occurred
determined	28e. Place of injury - At nome, farm, street, factory, off	fice 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
(Check only 2 Medical Exam	niner: On the basis of examination and/or investigation, in		

5 ☐ Other (specify)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific; completely filled in by the funeral director, to

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate has been signed by the irector, page 2 should be detached

Division of Vital Records, P.O. Box 68760,

State Registrar 201 East

4 Pregnant at time of death

9 Unknown

and address of person who completed cause of death (Item 23a) (Type, Print) University Parkway, Baltimore, MD 21218

29c. License number

Judy Kopinski 31. Date filed (Month, Day, Year) SEP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:32 PM MADDOX 9 09 ROBERT E. 0 0009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury
If Under 1 Year | If Under 24 Hrs. Hospice at th Cake Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 ☑ M 2 ☐ F Maryland 213-24-0038 1928 81 June 26, Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exp. in a fine that the notified at 1 ☐Yes 2X No Crisfield Director Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21817 27071 Gillette Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Nav 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 ☐ Married U.S. Baltimore, Maryland 21215-0036 1 □Yes 2 및 No Specify Specify: White 3 ₺ Widowed 4 □ Divorced Navy Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Superintendant Janes Island State Park 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Tyler Henry Norman Maddox ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27691 Crisfield-Marion Rd.-Marion Station, MD 21838 Robert E. Maddox, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 9/10/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bradshaw & Sons Funeral Home 21. Signatur uneral Service Lice Robert H. Bradshaw, 306 W. Main St.- Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCERN LUNG **Physician** disease or condition /Medical Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PHLMONARY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) Pregnant at time of death □Yes 2□No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably Gunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2E 1 □ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 E No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and fitte of certifier 2 20058416

State Registrar

DHMH 17 Rev 1/2001

6Harrin

31. Date filed (Month, Day, Year)

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of Mai	ryland / Depa <i>Cer</i>	rtificate of E			eg. No. 2	~ ~	313	523
ı	Physicia		Decedent's Name (First, Middle, Last HELEN	M.		MOORE		2. Date of Deat Month SEPTEMBI		o ^v 63	3. Time of 7:11	
4.	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. County	of Death		-
	Examini	٠.	UNION HOSPITAL			ELK'	ΓΟN		CE	CIL_		
I	Funeral Director		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV • 27 •	Year) 1913	9. Birthp Cour DELA	place (State on ntry) WARE	r Foreign
	p.		Usual Residence of Decedent		10. O'. T						10d. Inside Ci	ity I imits
	arylar show	Ä	10a. State 10b. County		10c. City, Town or Lo	ELKTO	NT.			'	1 ∐Yes	
	28a-f	Director	MARYLAND CECTION. Street and Number	L		10f. Zip Code		1	0g. Citizen of V	Nhat Cour	ntry?	
	with t		100 LAUREL DRIV	JE.			21921		U.S.		,	
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13. \	Was Decedent of Hi f Yes, specify Cubar		pecify Yes or No-	14. Rac	e - Ameri	can Indian,	
136	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show "affail Eva riner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? 1	0	f Yes, specify Cuba 1 □Yes 2 X No	n, Mexican, Puerto Specify:	Hican, etc.)	Specify	ck, White, y: WH	etc. HITE	
3200-61	in 72 hou n "natura nedicel E	Completed	15. Decedent's Ec (Specify only highest gra		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ation luring most of work)		16b. Kind of Bi	usiness/In	ndustry	
7	d with giene. r tha	E O	Elementary/Secondary (0-12)	College (1-4or 5+		HOMEMAK	ER		OWN	HOME		
פ	be filed Ital Hygi od other event, I	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Nam			ne)		
<u>I</u>	uld be Ments Irked Itic et	TOE	FELIX CICHOCKI				MARTH	A MARSZE	LEWSKI			
, Maryland	ges 1 and 2 should I it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (JANET A. GREBE /		l l	ng Address (Street a				State, Zij	p Code)	
altımore,	Pages 1 annent of He ant: If item ary or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of Dispo cemetery, cren GRACELAWN PA	natory or other plac	e) ! .		NEW CA	•		
Baltı	permit. Page Department Important: fi any injury o		21. Signature of Funeral S toe Lice	When MI	01170 S	Name and Address PICER-MUL	s of Facility LIKIN FU	NERAL HO	MES, IN	IC.	19720	
6	Physician / Medical Examiner sthe purisition and street st	al Examiner	23a Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate dust. Enter or actiful. Cause (Disease or injury that initiated events resulting in death) Last	a. Demo Due to (or as a b. Due to (or as a	a consequence of): a consequence of):						Interval Ber Onset and Umkm	ween Death
68760	ficate phys s the	edical		⊾ d								
C. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 ☐ Fetal death 3 [☐ Ectopic pregnanc ☐ Other (specify)	y			ate of deliv		Year
J.	that the ded by detax		Part II. Other significant conditions	contributing to death bu	it not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	itribute to	the cause of	death?
g	uires n sigr ld be	d by						1 □ Y	es 2 🗆 No	3 ☐ Pro	obably 4 🗗	Unknown
Reco	he law requir te has been s age 2 should	Completed						24a. Was a autop perfor	sy	prior to c death?	topsy findings completion of	available cause of
ā	hysician: The la his certificate ha I director, page 2	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only or				
>	nysici nis ce direc		examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursing H	lome 5 ☐ Resid	ence 6 □Ot	ther (Spec	cify)	
0	ng Pr fter th	Ë	27. Man of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	ry 28b. Time o		y at	28d. Describe h				
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification: To	2 Accident investigatio 3 Suicide 6 Could not be determined	on 28e Place of Inju	ıry - At home, farm, sti		Yes 2□No	28f. Location (S City or Tow	treet and Num n, State)	ber or Ru	ıral Route Nui	mber,
_	ne Hospita n 24 hours ne Funeral	Medical C	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or in	nvestigation, in my c	pinion, death occu	urred at the time,	date and place	nanner as , and due	stated. to the cause	(s)
	To th Within To th comp	Me	29b. Signature and tip of certifier 30. Name and address of person who S. S. Sachdes 31. Date filed (Month, Day, Year)	18m)		29c. Licens	e number 0,23327	2_	29d. Date sign 9. / 6			
,	4		30. Name and address of person who	mb, 126	eath (Item 23a) (Type, A, E High	Print) St El	25 m	12/92/				
İ	Sta Regista		31. Date filed (Month, Day, Year)	2009 32. Rygistra	ar's Signature	back						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED, #201 = For State Registrar FH, TCHD, 9/11/09, rk Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year <u>12:0</u>5^{ам} **Physician** 09/08/2009 Diane Marie Neale /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice House Easton Talbot 8. Date of Birth (Month, Day) Birthplace (State or Foreign
Country) If Under 1 Year Months Days If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number Funeral Hours 04/08/1943 1 ☐ M 2 F Maryland 216-38-8156 66 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 Yes 2 □ No Talbot MD. Easton Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 411 Hollyday Street 21601 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) d 2 should be filed within in and Mental Hyglene.
7 is marked other than "r Elementary/Secondary (0-12) Hostess <u> Tidewater Inn</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Sampson ဥ Helen Pauls 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st
Department of Health and
Important: If Item 27 is n
any injury or other traun Gregory D. Sampson/Son 411 Hollyday St., Easton, MD. 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 19 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (*Specify*) 3 Removal from State 09/12/09 Easton, Maryland Richardson Cem. 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral S ice Licensee 426 Dover Street, Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4r/mo Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2<u></u> No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5010 1 Yes Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation Injury 1 Natural 1 □ Yes 2 □ No

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After n 24 hours after death.

The Funeral Director: Af the full betely filled in by the full between the full betwe within 24

RK 3

State Registrar 2 Accident

3 ☐ Suicide

29a. Certifier

one)

29b. Signature a

4 Homicide

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

301

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

use of death (Item 23a) (Type, Print) 30. Name and address of person who comp

filed (Month, Day, Year)

6 ☐ Could not be

determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 1845 м **Physician** Sept. 12, Vanessa Rochelle Payne 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4785 Huron Ave. Apt. Prince George Suitland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/3/1955 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1□M 2√ 579-72-2231 54 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1X Yes 2 No notified Director MD Prince George Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be r 4785 Huron Ave. Apt. #6 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Henry Payne Alberta Paige Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenja Ford/Daughter Good Hope Rd. SE #509 Wash., DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 9/22/09 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 3831 Georgia Ave. NW Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Heart Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in tany, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Fibromyalgia Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c, Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

18

3 Registrar's Signature

Drine Chevely Mary

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) r^{Day}9, 2009 September **Physician** PHILBRICK 12:22P. M ROWE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Laure I

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day,
July 7, Prince George's Laurel Regional Hospital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Illinois 1 □ M 2 🗓 F 1921 88 325**-**28-4531 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f shov 1 Yes 2 No Prince George's Silver Spring Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examirer must be 20904 United States 3146 Gracefield Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces? 1 ∐Yes 2 ☑No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itel rry or other traumatic event, the Medical Experient 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Museum Curator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Charles Rowe Katharine Andrew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 104 Rebel Ridge Road Lexington, Virginia 24450 Richard Andrew Rowe -Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 9/17/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Bonald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee Donald 4400 Powder Mill Road Beltsville, Maryland 20705 twand Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Aspiration Pneumonia **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Cardiac Arrythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Puncar Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 1 □ Yes 2 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 vithin 2 to the F

20

State Registrar

29b. Signature and title of certifier

SEP

Tsion Berhane, M.D. LRH 7300 Van Dusen Road Laurel, Maryland 20705 22. Registrar's Signature 31. Date filed (Month, Day, Year) 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D055703

29d. Date signed (Month, Day, Year)

September 11,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan	•	artment r <i>tificate</i>				fental Hyg R	jiene eg. No.		3152
	Physici /Medic		1. Decedent's Name (First, Middle, I	bert, R	-111						2. Date of Dea Month September	Day . O	Year 2009	3. Time of Death 0442 am
0	Examir		4a. Facility Name (In not institution, of Mary Kind	give street and num	ber) Center	_	4b. City, To Baltin	own, or	Location	of Death			ty of Death	
	Funeral Director		5. Social Secdrity Number 6 216–22–8573	. Sex 1 X M 2 □ F	7. Age (In yrs. Ii 81	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day		9. Birthp Cour	lace (State or Foreign try)
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside City Limits
	e Mar Ba-fst	Director	MD Carrol	11		Han	npstea							1 ☐ Yes 2 🙀 No
	with th	Dire	10e. Street and Number	11 - D1			10f. Zip (7.4			0g. Citizen o	f What Cour	itry?
	eath v	Funeral	115 N. Houcksvil	12. Was Deced	lent Ever in U.S	S. 13.		2107 ent of Hi		igin? (Sp	ecify Yes or No-		ace - Americ	an Indian,
Rill 0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, I'm Modicol Examinar must be realthed at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford	ces?		lfYes, specil 1 □Yes 2	fy Cuba	n, Mexica Specify.	n, Puerto	Rican, etc.)	Spec	ack, White, ify: wh	ite
bert Ril. 21215-0036	thin 72 ho re. ran "natur Medicel	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)		4or 5+)	(Give	dent's Usual kind of work DO NOT use	done d	lurina mos	st of work	ing	16b. Kind of		,
A1b d 21	led will tygien her th	Co	6		·	servi	ice pr	opar			e (First, Middle,	Suburt		opane
g 4	uld be filed Mental Hygi arked other atic event, II	Be	17. Father's Name (First, Middle, La Walter Rill	(St)							Stoffle		ine)	
erling A	should and Me is mark	ျ	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street a			al Route Numbe		n, State, Zip	Code)
	and 2: ealth a n 27 is er trau		Ethel M. Myers,	sister		4601	Lynnc	rest	t Dri	ve,	Hampste	ad, Md.	. 2107	4
St. Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Removal from S		lace of Dispo emetery, crei	osition (Name matory or oth	e of ner plac	e)	[Date	20c. Location	n - City or To	wn, State
ţ <u>i</u>	permit. Pages Department of important: If Its any Injury or o		4 Donation 5 □ Other (Spe	cify)	Wes	sley U.						Hampst		Md.
Baj	permit. Departr Imports any Inju		21. Signature of Funeral Service Lic	ensee /	M0074						ine Fundampstead			
			23a. Part 1. Enter the disease, or co	omplications that ca	used the death								21079	Approximate
0	Physician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Aor	ch line.	Lenosi	is							Interval Between Onset and Death
	Examiner		Sequentially list conditions	b		,								
	ed sit	iner	Sequentially list conditions, if any, leading to immediate	Due to (d	or as a consequ	uence of):							- 4	
	execut and al-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (c	or as a consequ	uence of):								
8760,	icate be executed physician and the burial-transit	dical		d										
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 🗍 Fetal ant at time of d	death 3	☐ Ectopic pre☐ Other (spe		у				Date of deliv	ery Day Year
ds, P.	signed by the detail	by	Part II. Other significant conditions	s contributing to dea	ath but not resu	ulting in the u	nderlying ca	use give	en in Part	l.		bacco use co		he cause of death?
cor	w requ	Completed									24a. Was a	an 24	o. Were auto	ppsy findings available
Be	he lav te has age 2	omo									autop perfoi	sy med2	prior to co death?	mpletion of cause of
ta	ian: T	BeC	25. Was case referred to medical	I.					26. Plac	e of Deat	1 □ Yes th (Check only o	2 X No ne)	1 □ Yes	2,80,100
>	hysici his ce I direc		examiner? 1 ☐ Yes 2 X No	Hospital: 1XII	npatient 2 🗆	ER/Outpatie	nt 3 🗆 DO/	A Othe	er: 4 🗆 N	lursing Ho	ome 5 Resid	lence 6 🗆 🤇	Other (Speci	fy)
n o	ing P After t unera	on:	27. Manner of Death 1 Natural 5 ☐ Pending		f Injury n, Day, Year)	28b. Time o Injury		Bc. Injur Work	₹?	,,,	28d. Describe h	ow injury occ	urred	
Division of Vital Records,	or Attend ifter death Director:	Certification: To	2 Accident investigat 3 Suicide 6 Could no 4 Homicide determine	l ho	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str y)	M reet, factory,		Yes 2□]NO	28f. Location (S City or Tow	Street and Num n, State)	mber or Run	al Route Number,
	Hospital 24 hours a Funeral I	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the caminer: On the ba	sis of examina	wledge, deat	th occurred anvestigation,	at the tir in my o	me, date a	and place eath occur	, and due to the rred at the time,	cause(s) and date and plac	manner as e, and due t	stated. o the cause(s)
	To the within To the Somple	Med	29b. Signature and title of certifier	and main)		29c.	Licens	e number	,		29d. Date sig	ned (Month,	Day, Year)
	111/		Xal		m.l.		14	57	586	20	8	Septen	nber,	08,2009
	GTIVA		30. Name and address of person wi	no completed cause		1 23a) (Type,	Print)	10	5+	13a/	finore 1	MD 2	1201	08,2009
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signa		4		,					

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10 - 2009 **Physician** 1:25 JR Rains /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fruitland Wicomico 304 South Camden Ave. Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Months Days 1**X** M 2□ F Yrs 9/08/1947 Arkansas 62 Director 432-86-1093 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Mydical Examiner must be notified at 1 XYes 2 No Director Fruitland Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21826 304 South Camden Ave. Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No ð 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Navy Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Business Owner 12 es 1 and 2 should be filed w of Health and Mental Hygier I ttem 27 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Rains ۴ Harold Rains 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 304 S. Camden Ave., Fruitland, Maryland 21826 Deborah Rains/wife 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 9/14/09 salisbury, Maryland Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home P.A. 21. Signature of Funeral Service Licenses 501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final metastatec Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-tra Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buris the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month • the Funeral Director: After this certificate has been signed by the attempletely filled in by the funeral director, page 2 should be detached for 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2MNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After this Ampletely filled in the the state of the think the state of the think the state of the st 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and my opinion and my opinion.

En. State 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 1

E,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN

16 2009

Registrar

DHMH 17 Rev 1/2001

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M.D.

32. Registrar's Signature

29c. License number

030690

29d. Date signed (Month, Day, Year)

E Carroll 5t., 5.1.5600, MD 2180,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** V. Robinson September 18, 2009 4:20 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harwood Anne Arundel Mandrin Chesapeake Hospice House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 4, 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Days **Funeral** Hours **X**XXM 2□ F Ireland 050-12-2797 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liquy or other traumatic event, the "action Eventine must be mutified at some. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □ Yes 2√XX Director Prince George's Ft. Washington Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20744 9305 Ft. Foote Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

XXXYes 2 □ No 1942 11. Marital Status Black, White, etc. 1942-1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 🛣 No Specify: Specify: White þ 1946 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Budget Examiner Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robinson Margaret Allen Joshua ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9305 Ft. Foote Road Ft. Washington, Maryland 20744 Betty G. Robinson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 KMCremation 3 ☐ Removal from State 9/19/2009 Kalas Crematory Edgewater, Maryland 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signatur Funeral Service Licenses 20745 6160 Oxon Hill Road Oxon Hill, Maryland 115 . Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause complications the call sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mediate Cause (Final mace a **Physician** ens disease or condition resulting in death) /Medical ue to (or as a cons vuence of) Examiner OKSTA canc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last the attending physician and hed for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? 1∐Yes 2XXXINo 1 ∐Yes 2 ∐No or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence ANOther Spice House 1∐Yes 2∏XXo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of XX.Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Hospital XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO Name and address of person who completed cause of death (Item 23a) (Type, Print) 1R 6+1 31. Date filed (Month, Da State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** David Steger Claud 9:25a 2009 11 Sept. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Dove House Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2 □ F 4/2/1928 MD 218-32-5156 Director 81 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10h County 10c. City, Town or Location , or items 23a or 28a-f show 7 is marked other than "hatural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be modified at 1 ☐ Yes 2 X No Director York Hanover PA. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 17331 1700 Utz Terrace Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married white 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Md. Fresh Eggs Elementary/Secondary (0-12) College (1-4or 5+) egg_business retail owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary V. Coker George W. Steger, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1700 Utz Terrace, Hanover, Pa. Mary Pauline Steger, wife permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery 9/14/2009 Hampstead, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home 934 S. Main St., Hampstead, Md. 21074 Demmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eacy in e. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown certificate has been signed by rector, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 🗌 Unknown 2 □ No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 SOther (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 🔲 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending e Funeral Director Aft letely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 ho

To the Fune

completely f On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 2☐ Medical Exeminer and manne stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier WIL

State Registrar name and address of person who o

SEP

Year)

31. Date filed (Month, Day,

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department / De	artment of Health and M	lental Hygier	211111 31531
П	Physici	ian	Decedent's Name (First, Middle, Last)			Oay Year
	/Medic Examir		Richard Lee Stephan 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2009 0434 ^M 4c. County of Death
1	Ç.X.IIIII		Golden Living Center	Westminster		Carroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219-44-5088 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea June 20,	ar) 9. Birthplace (State or Foreign Country) 1947 Maryland
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lot	ocation		10d. Inside City Limits
	a-fsh	ctor	Maryland Carroll Westm	inster		1 ☐ Yes 2 ☑ No
	vith th	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ns 23e	eral	1234 Washington Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21157 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - American Indian,
5-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show the Madral Examir et must be notified at	by Funeral Director	No Never Married 2 ☐ Married 1 ☐ Yes 257 No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 🏂 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
21	thin 72 hours e. an "natural", Madical Exa	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	. Kind of Business/Industry
21	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me			enance Work	e (First, Middle, Maid	andom House
Maryland	ould be fi Mental H arked ot atic ever	o Be	17. Father's Name (First, Middle, Last) Charles Stephan		thy Bowers	
aryl	2 shoul and Me Is mark	은		ng Address (Street and Number or Run	-	
	1 and 2 Health a tem 27 Is			City View Ave.	Westminst	
lore	Pages 1 nent of H. int: If iter iry or oth		1 Burial 2 Cremation 3 Hemoval from State	matory or other place)		. Location - City or Town, State
Baltimore						nksburg, MD al Home & Chapel, PA
Ba	permit. Departn Imports any inju			12 Washington Rd.		- And the second
	Physician /Medical		23a. Part1. Enter the disease, or implication of a taused the death. Do not en shock, or heart failure. List only one cause) in each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Approximate Interval Batween Onset and Death
	Examiner	iner	Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury	In acul	ent	74
3760,	ate be executed hysician and he burial-transit	lical Examiner	that initiated events resulting in death) Last C. Due (or as a consequence of):			30gr
.O. Box 68	that the death certifica led by the attending ph detached for use as th	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	sign sign d be		Part II. Other significant conditions contributing to death but not resulting in the t	inderlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
I Records,		Completed			24a. Was an autopsy performed 1 Yes 2	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	Othor	th (Check only one)	
of	ding Phys	tlon: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	nt 3 DOA 4 Nursing Ho	ome 5 Residence 28d. Describe how i	e 6 Other (Specify) njury occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	the Rospital or hin 24 hours afte the Funeral Dir npletely filled in	edicai	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deal 2. Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occur	and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To T com	M	29b. Signature and title of certifier	29c. License number		Date/signed (Month, Day, Year)
ل	n. K. J		30. Name and address of person who completed gause of death (Item 23a); (Type In M. M. Middlettin 3337 Vice	fory Strent	man	19/200 9 chater 10 21102
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SFP 1 0 2009 According to the state of the stat	back		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Elton F. Strevig, Sr. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) **Examiner** Westminster Carroll Lookabout Manor 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Hours Deys Months M 2□ F Yrs. June 19, 1915 Director 219-14-7519 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or Nema 23a consent in the market other transmits event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Westminster Directo Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 21157 533 Bachman Valley Rd.

aritel Status

12. Was Decedent Ever in U.S.

Armed Forces? Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. White à 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Agriculture Farming 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Mary Magee George Strevig 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter 16210A Sabillasville Rd. Sabillasville, MD 21780 Donna D. DeLauter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State John Luther Miller Cem. 9/11/09 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 34 Maple Ave. Littlestown, PA 21. Signature of Funeral Service Licensee 17340 Little's Funeral Home 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) LUNG CANCER /Medical Examiner Examiner The law requires that the death certificate be executed ettending physician end for usa as the buriel-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the e should be datached 1 PYes 2 No 3 Probably 4 Unknown Mer > 15EX5E þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed LIPIDEMIA 1 ☐ Yes 2 ☐ No TL Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No Certification: To 1 Yes this 28d. Describe how injury occurred 27. Menn of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: Attar it completaly filled in by the funere nours after death.

Neral Director: After the filled in by the funere 1 Waturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Nedical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 2 Medi one) 29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILLP - RUZBARISKY M

31. Date filed (Month, Day, Year) SEP 1 0 2009

29b. Signature and title of

certifier

32. Registrar's Signature Drown

parks

29c. License number

25 AIRPORT DR WEST., MD 21157

State

Registrar

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		1	For State Registrar	•	•	ificate of L		R	eg. No.	0.00	21533	
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Month Day Year				
	/Medic	al .	Norma L. Stem 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loca			Location of Deat		3 EPTEMBER 15 2007 1:45 PM 4c. County of Death				
7	Examin	er	4a. Facility Name (If not institution, give street and number, Seasons Hospice at Northwe				lallstow		Baltimore			
	Funeral Director			e (In yrs. last birt		If Under 1 Year Months Days		8. Date of Birth			ace (State or Foreign	
	Maryland -f show	tor	Usual Residence of Decedent	10c. City, Town	or Loca	Elders	ourg			10	0d. Inside City Limits 1 ☐Yes 2 🛣 No	
	with the isa or 28a	Funeral Director	10e. Street and Number 1825 Vincenza Drive Apt. H			10f. Zip Code 217	784		10g. Citizen o	f What Count US		
036	filed within 72 hours after death with the Maryland Hygiene. Hygiene, with I had a say or 28a-f show ther than "natural" or Items 23a or 28a-f show ent, It a Medical Evantinat out to malified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Armed Forces 1 □ Yes 2 □ ☑ If Yes, Give Year or Dates:)		las Decedent of Hi Yes, specify Cuba □Yes 2 No	spanic Origin? (n, Mexican, Puei Specify:	Specify Yes or No- to Rican, etc.)	В	ace - Americ lack, White, e	tc.	
15-C	in 72 ho n "natur Nedical J	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occup ind of work done o O NOT use retired	during most of wo	rking	16b. Kind of			
7.12	led with tygiene her tha nt, lies		Elementary/Secondary (0-12) College (1-4or 2 2 17. Father's Name (First, Middle, Last)	54)	Re	gistered		me (First, Middle,	Maiden Surn		th Care	
and	d be fi) Be	William C. Strange				Beu1	ah Eliza	beth M	oore		
Maryi	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Immortant: if time 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it allocated Evaninating the multified at once.	2	19a. Informant's Name/Relationship (Type. Print) Mrs. Sheila Gordon (Execut		. Mailing	Address (Street of Heatherw	Beulah Elizabeth Moore Street and Number or Rural Route Number, City or Town, State, erwood Way Sykesville, MD 217			vn, State, Zip	Code)	
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			ition (Name of atory or other place Mem. Pa:	rk 9/1	Date 9/2009		n-City or To ville,		
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licensee	MO0 76"	22. H	Name and Addre AIGHT FUI O Box 19	ss of Facility NERAL HC 5 Sykesy	ME & CHA	PEL, P 21784	PEL, P.A. 21784		
/Med Exami	ifficate be executed Sphysician and By the purial-transit	ical Examiner	edical Examiner	resulting in death) Due t (or a Black or a	iine.	of):	Ivre		ac or respiratory at	rest,		Approximate Interval Between Onset and Death
O. Box	The law requires that the death certifit at has been signed by the attending I age 2 should be detached for use as	by Physician/Me		2 Fetal death at time of death		Ectopic pregnanc	sy .			Date of deliv Month	Day Year	
ds, P.	uires that n signed b Id be deta	d by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPSIS DIABETES MELLITUS						23e. Did tobacco use contribute to the cause of dea			
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/ita	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			l Ott	26. Place of D	eath (Check only	one)	SEASO	ms HOSPICE	
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Division	fter The	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Ö	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physician: To the be	et of my knowledg	ge, deat	h occurred at the t	ime, date and pla	ace, and due to the	e cause(s) an	d manner as	stated.	
	To the Hc within 24 To the Fu	Medical										
	Wil		30. Name and address of person who completed cause of	f death (Item 23a)) (Type	174°	5931		Sopt	6mbe	r 15, 2009	
	`		30. Name and address of person who completed dates of the complete	5 46 Strar's Signature	2/	OLD COU	RTROAL	RANDI	MISTO	WN I	, Day, Year) BY 15. 2009 MD 21133	
	St Regist	ate rar	SEP 18 2009	was p	9.	parker						

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		-	For State Of Waryia		ertificate of De			Reg. No. 🤉 🗍	60	31531			
H	115		Decedent's Name (First, Middle, Last)				2. Date of Dea	Day	Year	3. Time of Death			
	Physicia /Medic		Francis Augustus Stem,	Jr.			Sept.	12, 20	09	6:50pm [™]			
5	Examin	-	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc			4c. County	of Death Carro	.11			
_			Lorien Health & Rehabilitation 5. Social Security Number 6. Sex 7. Age (In yra	l last hirthda	Mt. Ai		8. Date of Birl	h					
	Funeral Director		213-34-04/1 A /2					Cour	place (State or Foreign				
	and w	1	Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or I	Location				1	0d. Inside City Limits			
	Maryl f sho	ō	MD Carroll	E1de	ersburg					1 ☐ Yes 2 🛣 No			
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of		ntry?			
	h with		2032 A Rudy Serra Drive		21784				USA				
	ems semu	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13	 Was Decedent of Hispa If Yes, specify Cuban, N 	anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra Bla	ce - Americ ick, White,				
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give Year or Dates 959-			Specify:		Speci	MIII				
2	72 ho natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occupation we kind of work done during the bull of the bull of work done during the bull of the bull o	n ng most of work	ing	16b. Kind of E	Business/In	dustry			
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2	led w tygiei her ti	S	12 17. Father's Name (First, Middle, Last)			. Mother's Nam	e (First, Middle	, Maiden Surna		,			
anc	d be find the find th	Be C	Francis Augustus Stem, Sr.					h Rosie					
<u> </u>	should and Men s marke umatic	ပ္	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	ailing Address (Street and	Number or Ru	ral Route Numb	er, City or Town	n, State, Zij	p Code)			
Maryland	nd 2 shoulth and 27 is mare r trauma	3	Mrs. Ruth Ann Stem (Spouse)	203	2 A Rudy Ser	ra Driv	re, Elde	ersburg	, MD :	21784			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show mimportant: if item 27 is marked other than "natural", or items 23a or 28a-f show important; if item 27 is marked other than "natural", and "and injury or other traumatic event, the Medical Examiner must be notifiled at once.		20a. Method of Disposition 20b		sposition (Name of crematory or other place) ew Mem. Park		Date 7/2009	20c. Location Sykes	•				
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee	764	22. Name and Address of HAIGHT FUNE PO Box 195		IE & CHA	APEL P	.А.				
			23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.		enter the mode of dying, s	such as cardiac	or respiratory	arrest,	P	Approximate Interval Between			
	D		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Lia	· theo	A di	-puc	2	1	Onset and Death			
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		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):	.1 77					1110			
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		Me	IF FEMALE: 23c. If yes, outcome pf pre	gnancy				23d. [ate of deli	very			
O. Box	e death certif the attending ned for use as	/sician	/sician	/sician	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	etal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				Month	Day Year
٦.	faw requires that the de as been signed by the a 2 should be detached	by Phy	Part II Other significant conditions contributing to death but not	resulting in th	e underlying cause given	in Part I.		tobacco use co		the cause of death?			
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E	Th ate pag	S	ATHA FIBRILLATION,	CNO	RIC KIOWE	y Viser	1□ Yes	2€ No	1 ☐ Yes	2 No			
Viti	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		2 Other:		th (Check only	one) sidence 6 □0	Whor (Cno.	nife()			
ō		2	1 ☐ Yes 2 ♠ No ☐ No	28b. Tim	ne of 28c. Injury a			how injury occ		ony)			
	ding P. h. After funer	tion	1	r) Inju		es 2 🗆 No							
Division	or Atten after deat Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp	t home, farm ecify)	, street, factory, office		28f. Location City or T	(Street and Nucown, State)	mber or Ru	ıral Route Number,			
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my conditions on the desired form one) Certifying Physician: To the best of my conditions on the desired form one of the desired form of the desired form one of the desired form one of the desired form of the desire	knowledge, d nination and/d	death occurred at the time or investigation, in my opin	e, date and place nion, death occ	e, and due to thurred at the tim	e cause(s) and e, date and place	manner as e, and due	stated. e to the cause(s)			
		Mec	29b. Signature and title of certifier	1 11	29c. License r	number 7	49	29d. Date sig	ned (Mont	h, Day, Year)			
	WIL		30. Name and address of person who completed cause of dethy	Item 23d) (Ty	/pe, Print)	10-1	Fash -	Rive	m	del 2170:			
	S	tate	31. Date filed (Month, Day, fear) 32. Registrar's S	ignature	se me,	- 1, 1		NO.	1	-1 21/0/			
	Regis		SEP 18 2009 Leneur	J B.	Sacker								

DHMH 17 Rev 1/2001

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			For Amend Items 23artin, 23 per me, g 1 - State Registrar	itment of Health and I rtificate of Death	Mental Hygien Reg. N	e 2002 31535
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D	3. Time of Death
	Physicia /Medic		James Seth		September	09, 2009 01:11
3	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
· ·			University of Maryland Medical Center	Baltimore		
	Funeral		5. Social Secufrity Number / 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Director		219–36–7004 TIME 1 69 Usual Residence of Decedent		03-12-1	940 Maryland
	and		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mary f she	jo	Md. Dorchester Hurloc	l _r		1 XYes 2 ☐ No
	the	Director	10e. Street and Number	10f. Zip Code	10g. C	Ditizen of What Country?
	3a ol		113 Gold rush Lane	21643		USA
	filed within 72 hours after death with the Maryland Hygene. Hysener and	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,
9	or ite		Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, etc.
8	ral", c	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □Yes 2 No Specify:		Specify: Black
21215-0036	72 hc natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work		Kind of Business/Industry
7	ithin ne. han "	Id II	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
2	led w Hygie her t		10 Me	chanic 18 Methoda Nor	e (First, Middle, Maide	llen Family Foods
anc	be fi	Be			, ,	,
Ë	should and Mer s marke umatic	유	John Wesley Seth, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Maili	mg Address (Street and Number or Ru	Elizabet	h Smith
Maryland	C 10					
	1 and Health em 27 other tr		Yvonne Seth / Wife 113 20a. Method of Disposition 20b. Place of Disp	Gold rush Lane	Hurloc	Maryland 21643 Location - City or Town, State
ē	Pages nent of int: If its iry or o		Manual 2 Defendation 3 Defendoval from State	i	Į.	
altimore,	artme artme ortani injury	1	4 □ Donation 5 □ Other (Specify) Sandton 21. Signature of Funeral Service, Licensee	wn Cemetary 09- 2. Name and Address of Ficility	16-09 H	illsbere, Md.
Ba	permit. Departr Importa any inju	1		Be	nnie Smit	th Funeral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	16 S. Main St.,	Hurlock, I	Md.21643
			shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory urrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition a. As piva 11011			6 hes
	Examiner		Due to for as a consequence of):			10/1
		ē	Sequentially list conditions, The properties of the sequence			17 days
	uted d ansit	Examiner	tany, restricting to fining date, cause. Enter Underlying Cause (Disease or injury	and Reice	Figur 1	WHITER 30 days
Ć	ficate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):	ausplant Reject	COLD CONFORMAN	EDICAL EXAMINATION OF THE PROPERTY OF THE PROP
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	rtifica ng ph as th	ledi		1550	ICH KOM.	
ŏ	th celliendir	W/ue	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery
O. Box	dear death	Physician/Me	1 _ Yes 2 _ No 4 _ Pregnant at time of death 5	Other (specify)		Month Day Year
<u>P</u> .	at the I by th	hy	9 Li Unknown			
Ś	w requires that the death certific been signed by the attending should be detached for use as	β	Part II. Other significant conditions contributing to death but not resulting in the u	1 61		o use contribute to the cause of death?
Division of Vital Records,	equir	ted	,	te Fulucy	1 ☐ Yes	2 No 3 Probably 4 Unknown
င္ပ	law r las be 2 sh	Completed by	lujury due to Complications of Chro	nic Lung Disease	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The rate h	Š	1 /		performed 1 ☐ Yes 2 🔏	death?
/ita	clan: ertific ector,	Be (25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	
\leq	this c		1 XYes 2 Hospital: 1 Inpatient 2 ☐ ER/Outpatie		ome 5 Residence	6 ☐ Other (Specify)
בַּ	ing P	on:	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) Injury	Work?	28d. Describe how in	jury occurred
si Si	tend leath. lor: / the fi	cati	2 Accident Investigation	M 1 Yes 2 No	-4-04	
<u>≅</u>	or At fter d Sirect in by	Certification: To	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	pital burs a eral (29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th accurred at the time, date and place	and due to the cause	a(e) and manner as stated
	To the Hospital or Attending Physician: The law requires that the death certification is the hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)			
	othe vithin othe	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
	->- o		7	DCA: ALLUMNI LET E	C10099 C	tala 19 7000
•			30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	1137/1 Dep	stainber 09, 2009
R	2K3		Thomas Sincex MD, ZZ S. Greens	St. Baltimer	e MD Z	1201
	Sta	te	31. Date filed (Month, Day Year) 32. Rigistrar's Signature	Print) 2 St., Baltimero barles	1	
	Registr	ar	SEP 1 1 2009 Senera B.	ace		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 11:50P 09 10 2009 Daniel Seney, Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Easton

Vear If Under 24 Hrs.

Min. Talbot Talbot Hospice House Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Days Hours 1**⊠**M 2□F 05-18-1928 Maryland 220-26-3887 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 XYes 2 No Centreville Md. Queen Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21617 USA 301 N. Liberty Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ¥Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker Construction Construction 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie Baynard Daniel Seney, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) N. Liberty St., Centreville, Md. 21617 Alma Seney / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Vertrans Cem. 09-16-09 | Hurrown,
22. Name and Address of Facility Bennie Smith Funeral Home Donation 5 ☐ Other (Specify) 426 Dover St., Easton, Md. 21601 Approximate Interval Between that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complication

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once.

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

7. Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death when of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23

Baltimore, Maryland 21215-0036

burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

within 24 hours after death

To the Funeral Director:
completely filled in by the

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	Immediate Cause (Final disease or condition	Coronary	Artery 7	Diseusc			Onset and Death			
Examiner	resulting in death) Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Artery 7	al D	iscale		Years			
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	blivery Day Year								
ed by PI	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause giver	ı in Part I.			to the cause of death? Probably 4 Unknown			
omplete					24a. Was an autopsy performed 1☐ Yes 2☐	prior to death?	autopsy findings available completion of cause of s 2 □ No			
Be	25. Was case referred to medical	26. Place of Death (Check only one)								
20	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6					ecity) Hospice House			
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time	y Work?	at ? es 2 ∐ No	28d. Describe how i	njury occurred				
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined					reet and Number or Rural Route Number, , State)				
Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
Me	29b. Signature and title of certifier	Date signed (Mo								
	30, Name and address of person who Adam Weinstein	completed cause of death (Item 23a) (Type	Dutchman	5 Lane	e Easte	n MD	21601			

Registrar

State

RK 3+VA

SEP 15 2009

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Simms Henry Byron September 13,2009 4:30a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Charlotte Hall 13529 Shrewsbury Ct. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month Days | Hours | Min. | May 15, 1947 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Washington DC 62 579 64 2138 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show s 1 and 2 should be filed within 72 hours after death with the Marylar of Heath and Mental Hygiene. It has a 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show cother traumatic event, it is involved it with the mouthfied at 1 SYes 2 □ No Director Charlotte Hall MD Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 20622 13529 Shrewbury Ct. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

12☐Yes 2☐No 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1∐Yes 2. Man Specify If Yes, Give Year or Dates: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Washington DC/ Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Prince Georges Co. Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Davie Moses John Simms မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 13529 Shrewbury Ct. Charlotte Hall, MD20622 Frederina T. Simms/wife permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cem 9-21-09 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Signature of uneral Service Licensee 2294 Old Washington RD Waldorf, MD 20601 moul lone TOA 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on end line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final ~ce **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed Exami burial-trar and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signal, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Attending Physician: The certificate 2 No 1 ☐ Yes 2 No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner' Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deat 1 Natural 5 Pending death. 2 ☐ Accident 3 ☐ Suicide investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month. Day, Year) SEP 172009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Redistrar's Signature

and manner stated.

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Manth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Items 15,16a per inf princate of Beauty Amend Items 15,16a per information of Health and Mental Hygiene

			For State Registrar	Amend Ite	ms 15,16a pe	r inte	Ranga e	12/10dhb	wientai riy	Reg. No.	10 21533
	Physici		1. Decedent's Name	(First, Middle, Last)	orrone		Sm	i+h	2. Date of De Month		3. Time of Death
1	/Medic Examin		4a. Facility Name (If	not institution, give	street and number)		4b. City, Tow	n, or Location of Deat	h	4c. County of E	
- All			Washir 5. Social Security Nu		dventist	rs. last birthday)	Take If Under 1 Ye	ar If Under 24 Hrs	Jark B Date of Bir	Mont	Birthplace (State on Foreign
	Funeral Director		36674 Usual Residence of	8429 10	M 2XF 7. Age (/// y	Yrs.	Months Da			7 1945	Country)
	yland		10a. State	10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f st	ctor	MD	Prince G	reorges +	Hatt	SVII	e			1 □ Yes 2 XNo
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprision in the Intest be notified at once.	al Director	10e. Street and Num	har les	ston Pla	ce	10f. Zip Coo	783		10g. Citizen of Wha	t Country?
	tems	Funeral	11. Marital Status	3.2	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - / Black, V	American Indian, Vhite, etc.
5-0036	ours afte rral", or l	ğ	1 Never Marrie	•	1 □ Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2			Specify:	Black
15-	n 72 h "natu	Completed	(Speci	15. Decedent's Educify only highest grade	cation e co <i>mpleted)</i>	(Give	dent's Usual Oo kind of work do DO NOT use re	ne during most of wo	rking	16b. Kind of Busin	ess/Industry
2121	withi giene. r than	mo	Elementary/Secor	ndary (0-12)	College (1-4or 5+)	LP1	Reg	sistered N	urse	Nursin	a Hame
bu	e filed al Hygi I other vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname)	9
yla	should band Ment s marked umatic e	2	Mack		ims			Lula	Clar		
Maryland	d 2 sho th and 7 is ma trauma			me/Relationship (Ty)	rpe. Print)	19b. Maili	,	reet and Number or R			
_	f Health f Health tem 27 i		20a. Method of Disp	osition		D. Place of Dispo	Charle osition (Name o	f i	Date	20c. Location - City)
Baltimore,	permit. Pages 1 Department of H Important: If ite any Injury or ot			☐ Cremation 3 ☐ R 5 ☐ Other (Specify)	Removal from State		matory or other		210/700	Ft Pier	me El
alti	permit. Departn Importa any Inju		21. Signature of Fur	neral Service License	ee	2:	2. Name and Ad	Idress of Facility 🧲	reene	Funera	rce FL -
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			shock, or hear	rt failure. List only or	ications that caused the dene cause on each line.	eath. Do not en	ter the mode of	dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
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7	Examiner				Due to (or as a cons	equance or):					
8	T #	ner	Sequentially list con cause. Enter Under Cause (Disease or i	nditions, insulate riving	Dun to (ur as a cuns	equation of:					
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68760,	icate be executed physician and s the burial-transit	alE	· · · · · · · · · · · · · · · · · · ·		Due to (or as a cons	equence or):					
687	tificate ng phys as the	edic						· · . · . · . · . · . · . · . · .			
Вох	attendin for use	an/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome of pred		∃Ectopic pregn	angy		23d. Date o	*
Ö	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 r 1 ☐ Yes 2 9 ☐ Unknown	nonths?	4 ☐ Pregnant at time of		Other (specify			Month	Day Year
o, o	s that gned b e deta	by PI	Part II. Other signifi	cant conditions cor	ntributing to death but not r	esulting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
Vital Records,	w requires been sign should be			·					1 🗆 '	Yes 2□No 3□	Probably 4 Unknown
Sec.	e 2 sh	Completed	-						24a. Was	psy prio	re autopsy findings available r to completion of cause of
alF	ian: The l rtificate hator, page								1 □ Yes	rmed? dea 2 DNo 1 □	th? Yes 2 □ No
ΖÏ	Se Se	Be	25. Was case referrence examiner? 1 ☐ Yes 2		lospital:	d'en a		Othor:	ath (Check only o		
	g Physer this eral dii	n: To	27. Manner of Death		1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time o	f 28c. I	4 □ Nursing F njury at		dence 6 Other ((Specify)
io	Attending or death. ector: After by the fune	atio	1 Natural 2 Accident	5 Pending investigation	(Month, Day, Year,	1 Injury		Vork? 1 □Yes 2 □No			
Division	after de Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, strectfy)	eet, factory, offi	ce	28f. Location (City or To	Street and Number own, State)	or Rural Route Number,
	nou nei	Medical C	29a. Certifier (Check only one)		sician: To the best of my line: On the basis of exame and manner stated.						
	To the Ho within 24 To the Fu completel	Me	29b. Signature and t	title of certifier	1 1		29c. Lic	ense number		29d. Date signed (Month, Day, Year)
			· (//,	MI IX	ell II			9478		9/18/	09
0	10		30 Name and avoire	ss of person who do	ompleted cause of death (I	tem 23a) (Type,	Print) //	14 /	Thomas	1	1 M O
			31. Date filed (Month	h, Day, Year)	32. Registrar's Sig	CO (C	ive	TUR	a con	a lark	(MI)
	State Pagietre		CER 9 1		SEL Hogistian 5 oig	1.01	•	,			

			State of Marylan	•	artment of H				6.8	1 100	- 5 / 1
			Registrar 1. Decedent's Name (First, Middle, Last)		lineate of L	Jeaur	2. Date of Death	g. No.		3. Time of D	eath
	Physicia		Leonard R. Shannon, Sr.				Septembe	Day	Year	1645	М
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	-	4c. County			
		-	7719 Orange Tree Court			Heights			e Geor	rqe's	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	9. Birthpla Countr	ice (State or i	Foreign
Н	Director		239-20-8376 1M M 2U F 65	Yrs.			05/15/1	724		NC	
	/land			ty, Town or Lo	cation				100	d. Inside City	Limits
	Mary a-fsh	햦	MD Prince George's Cap	oitol F	leights					1 X]Yes 2	! □ No
	or 28	Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of \	What Countr	y?	
	23a (la I	7719 Orange Tree Court		20	3743			AZU		
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of His of Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		ce - America ck, White, et		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 🕱 Divorced Year or Dates:		1 □Yes 2 No	Specify:		Specif	Blac	K	
1215-003	172 hours after death with the Maryland "natural", or items 23a or 28a-f show selest Evaniner must be notified at	ted	15. Decedent's Education		dent's Usual Occupa			6b. Kind of B	usiness/Indu	ıstry	=
215	within 72 hc piene. r than "natul	ed L	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	kind of work done d DO NOT use retired,	furing most of woi)	rking				
2	filed within Hygiene. rther than "	Completed	12 4	Teach				chool/		tion	
n D	d d d d d d d d d d d d	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, Ma		ne)		
3	3 ≥ 5 5	မ	Lionel Shannon	10. 11.15			pe Griffi		04-4- 7:-	2-4-)	
Baltimore, Maryland 2	12s thar 7is trau		19a. Informant's Name/Relationship (Type. Print) Terri M. Shannon/Daugher				ural Route Number, Capitol				
ē,	s 1 and if Health item 27 other to		20a. Method of Disposition 20b. F		sition (Name of natory or other place		 	0c. Location			
Ë	e = 5		I Buriai 2 (A) Cremation 3 Li Removas nom State	cemetery, cren 2 sapea k		1	17/2009 B	oltevi	110- 1	ΔD	
alti	permit. Pag Department Important: any Injury once.		21. Signature of Funeral Service (icensee				rickland				
ñ	S a m s		Jake Studens	I			-¬ Camp S			20748	
			23a. Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	h. Do not ent	ter the mode of dying	g, such as cardia	c or respiratory arre	st,		Approximate Interval Between	
-	Physician		Immediate Cause (Final disease or condition	MA	GA	MMON	ATHY		(Chset and Do	rath.
2	/Medical		resulting in death) Due 1, (or as a conseq	uence of):	15	Don-	0.75			lena	
	Examiner	_	Sequentially list conditions, b.	14	01	LKODI I	AIC		·	ICHIL	7
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):	- MURI	ania	DISEV	ISE	11	LAPS	~
	execun and al-train	Xar	that initiated events resulting in death) Last c. Due to (or as a conseq	uence of):	Cind	VICE.	POLF	100	4		
8760	certificate be executed ording physician and ise as the burial-transit	dical	d.								
99	rtificate ng phys as the	ledi							1		
Box	leath certific attending p for use as	an	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregnancy	v		l l	ate of deliver	•	
	e death the atten ned for u	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of c		Other (specify)	,		M	onth f	Day Ye	ear
<u>ч</u>	w requires that the di been signed by the should be detached	Phy	9 ☐ Unknown Part II. Other sign#jcant conditions contributing to death but not res	ulting in the u	nderlying cause give	on in Part I	23e Did tob	acco use con	tribute to the	e cause of de	ath?
Vital Records,	signe signe d be d	d b	HUPFRIPIDEMIA	arang in are ar	nderlying oddse give	on in a cit i.	1 □ Yes	V		ıbly 4 🗆 Ur	
Ö	v requ	Completed by	DARK INISONIS				Die Wesen	-,,	More outon	sy findings a	milable
Ř	e la has e 2	Ę.	11119(11450765				24a. Was an autopsy perform	. 1	prior to con death?	pletion of car	
ta			25. Was case referred to medical			26 Place of Do	1 ☐ Yes 2 ath (Check only one	Z(No	1 ☐ Yes	2□No	
<u> </u>	is cer direct	o Be	examiner? 12 Yes 2 □ No Hospital: 1 □ Inpatient 2 □	ER/Outpatier	nt 3 DOA Othe		dome 5 Resider		her (Specify)	
0	rding Physician: th. After this certifics funeral director, p	Certification: To	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day, Year)	28b. Time of Injury			28d. Describe how				
Division	endir	atic	2 Accident investigation			Yes 2□No					
ž	or Att fter de iirect n by t	ŧ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Specif	ome, farm, str fy)	reet, factory, office		28f. Location (Str. City or Town,		ber or Rural	Route Numb	er,
	pital ours a eral C	ပ္သ	200 Cortifier - autifuling Physician Table hast of my land				and durate the se			otod	
	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director, I	edical	29a. Certifler	wieuge, deat ation and/or in	nvestigation, in my o	ne, uate and plac pinion, death occ	e, and due to the ca urred at the time, da	te and place	, and due to	the cause(s)	
	To the within To the сотры	Med	29b. Signature and title of certifier		29c. License	e number	29	d. Date signe	ed (Manth, L	Day, Year)	
	0		· / / /		Dal.	0(09		9/11	019		
	Ц		30. Name and address person who completed cause of death (Iter	n 23a) (Type,	Print)		go Mda	1	6	ncon 1	2000
	٦	, (b)	1100 Mekcantile In	STI	= 130) Lar	go Mdi	10774	1 501	ye L	some
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ure		,	1				

			For State of Mar State of Registrar		artment of He ertificate of D			erie g. No. 🥠 🚹 📆	0 2151.1
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	3. Time of Death of 09 7:45 P
	/Medic		Laura Juanita Smith 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Septembe	r 11, 20	
)	Examin	er				ver Sprin	σ		tgomery
	Funeral		Springvale Terrace 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)) If Under 1 Year	If Under 24 Hrs.			Birthplace (State or Foreign
	Funeral Director			86 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1	922	Country) Ohio
			Usual Residence of Decedent						
yland	Wor #		10a. State 10b. County 1	0c. City, Town or Lo	ocation				10d. Inside City Limits
Mar	a-fs	Director	Maryland Montgomery		S	ilver Spr	ing		1 ☑ Yes 2 ☐ No
h the	1 28	ire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
3-UU36 72 hours after death with the Maryland	23a	al	8750 Georgia Ave 209-B		2091	10		United	States
deat	E E	Funeral	11. Marital Status 12. Was Decedent Every Armed Forces?	er in U.S. 13.	. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		merican Indian,
after	a E		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ANo	Specify:	, ,,,,,,,,		African
ZIZIO-UUSD d within 72 hours aft	E 0	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:						American
22 hg	natu	ete	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupa e kind of work done d	uring most of work		6b. Kind of Busine	ss/Industry /ersity of
thin L	a a a	npl	Elementary/Secondary (0-12) College (1-4or 5+)	`life.	DO NOT use retired)	essor	D-		of Columbia
V Pe	ygier ver th	Completed	4						or dorumbia
Maryland d 2 should be file	d off even	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
V Q	Men arke	ဥ	Warren S. Shaw				ortia Sh		
2 sh	ls m		19a. Informant's Name/Relationship (Type. Print)		ling Address (Street a				
and	m 27 m 27 her t		Stephanie Morris/ Daughter					c, Khode Oc. Location - City	Island 02906
ore les 1	if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		oosition (Name of ematory or other place		ember	oc. Location - Oily	or rown, State
Pac	men ant: ury		4 □ Donation 5 □ Other (Specify)	Lee's	Crematory	7 18,	2009	Clint	ton, Maryland
Dalumore,	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be retified at once.		21. Sign sure of Funeral Strvice Luens e	MELL	Name and Addres				
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
∌ Pŀ	nysician	(J)	Immediate Cause (Final	tic Cance					Onset and Death 4 months
	Medical		resulting in death)	consequence of):					, montant
E	xaminer								
		Je	Sequentially list conditions, if any, leading to immediate Cause (Olsease or injury	consequence of):					
cutec	nd ransi	Examiner	tnat initiated events 👚 c.						
Ç,	an al rial-t	Ä	resulting in death) Last Due to (or as a	consequence of):					
. BOX 68/6U, death certificate be executed	attending physician and for use as the burial-transit	edical	d						
rtifice	ng ph as th	Jed	IF FEMALE:	-					
BOX	tendi r use	l/ue	23b. Was decedent pregnant		B Ectopic pregnancy	<i>y</i>		23d. Date of Month	delivery Day Year
	a D	Sicient	1 Yes 2 No 4 Pregnant at ti		Other (specify)			Month	Day Tour
requires that the	ned by the	Physician/M	9 Unknown				OO- Distant		te to the cause of death?
S, es th	igned be de	by	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause give	en in Part I.			
	should I				· · ·	-	1 L Ye	s 21X No 3	Probably 4 Unknown
VITAL RECORDS, sician: The law requires t	has be le 2 sho	Completed					24a. Was an		e autopsy findings available to completion of cause of
r e	_ <u> </u>	E					perform 1 ☐ Yes 2	ned? deat	
an: an	certificate ector, pag	Φ	25. Was case referred to medical			26. Place of Dear	h (Check only one		
OT VITA Physician:	.s. : □	0.0	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatien:	t 2 🗆 ER/Outpati	ient 3 DOA Othe	er: 4🏝 Nursing He	ome 5 Reside	nce 6 Other (Specify)
		Ē.	27. Manner of Death 28a. Date of Injury	28b. Time Year) Injury		y at	28d. Describe ho	w injury occurred	
/ISION Attending	ath. rr: After ne funer	atic	2 Accident investigation		M 1 🗆	Yes 2 □No			
DIVISION l or Attending	after death Director: d in by the f	E	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, s	street, factory, office		28f. Location (Str. City or Town	reet a <i>nd Numb</i> er o , <i>St</i> ate)	r Rural Route Number,
5 <u>§</u>	al Din ed in	Certification: To							
Hospi	within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of € and manner state	examination and/or	ath occurred at the tir investigation, in my o	me, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
o the	o the	Me	29b. Signature and title of certifier		29c. License	e number	29	9d. Date signed (M	fonth, Day, Year)
ř	ک≒۶۰		10.01.6	an	D	33224		09/16	/09
				oth /Itam 00c) /5				-5, -0	
0	Q		30. Name and address of person who completed cause of dea Ram S. Trehan, M.D. 1400 Fo			5 Silver	Spring	MD 2091	0
_	0					DITACT	ohr Tug'	2071	
	Sta Regist	ate rar	SFP 2 1 2009 Augus A.	's Signature					

		-	For State Registrar	State of Marylar		rtment (<i>rtificate</i>				giene Reg. No.	000	3 5 4	din construction did
Physi	iciaı	n	1. Decedent's Name (First, Middle, Last) Emma R.	Torres		_			2. Date of Dea Month Septem	Day	16, Year 2009	3. Time of Death 2:49p	
/Med Exam			4a. Facility Name (If not institution, give Holy Cross Hospit					cation of Death			ounty of Death	ry	
Funera Directo			5. Social Security Number 6. Sec		last birthday) Yrs.	If Under 1	Year If	Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Aug. 29	h // Year) 1 9	Count	ace (State or Fore y) luras	ign
		ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Mon	tgomery 10c. Ci	ty, Town or Lo	cation r Spri	ng					d. Inside City Lim 1 ∐Yes 2 🏽	
with the 3a or 28		DIE	10e. Street and Number 1503 Windham Lan	e		10f. Zip C 209				10g. Citize USA	en of What Counti	ry?	
If L I S 10-UU30 filed within 72 hours after death with the Maryland Hygiene. wither than "natural", or items 23a or 28a-f show ant, to shoften Even or count to molified		by Funeral Director	11. Marital Status 1 ★ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 X XIo If Yes, Give Year or Dates:		Was Deceder If Yes, specify		anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - America Black, White, et Specify: Wh		
nd ZIZID-UUSO e filed within 72 hours afi al Hygiene. I other than "natural", or vent, the middle Even		Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. I	dent's Usual (kind of work DO NOT use sekeep	done duri retired)	on ing most of worki	ing		of Business/Indi	ustry	
Viand Autor	1	å	17. Father's Name (First, Middle, Last) Romulo Torres					3. Mother's Name		Maiden S	urname)		
baltimore, Maryliand Z permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other traumatic event.	1	ရ	19a. Informant's Name/Relationship (7) Mario Torres /Son				Street and	d Number or Run	al Route Numbe		Town, State, Zip		
nore, ages 1 an ent of Hea nt: If item?		- Ci	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ f 4 □ Donation 5 □ Other (Specify)	Removal from State	Place of Dispo cemetery, crer te of H	natory`or oth	er place)	. Se	oate pt. 22 2009		ation - City or Tov		 nd
Baltimor permit. Pages Department of Important: If its any injury or o	once.		21. Signature of Funeral Service Licens		1			Collins ty Blvd	Funera	1 Ηοπ			
Physicia /Medica	an al		23a. Part 1. Enter the disease, or o m. shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ications that caused the dea ne cause on each line. a. Gastric Car Due to (or as a conse	ncer	ter the mode	of dying,	such as cardiac	or respiratory a	rrest,	21 1497 (4 - 1)	Approximate Interval Between Onset and Death 8 weeks	1
58 / 6U, ficate be executed physician and s the burial-transit		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (bisease of injury) that initiated events resulting in death) Last	Due to (or as a conse									
O. BOX () ne death certi the attending thed for use a		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	d	tal death 3	□ Ectopic pre				2:	3d. Date of delive	ry Day Year	
ords, P. requires that the seen signed by nould be detact		ρ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	ınderlying caı	use given	in Part I.		_	se contribute to the		
The lar ate has	,	Completed					-			psy ormed? 212No	24b. Were auto prior to cor death? 1 ☐ Yes	psy findings avail npletion of cause 2 No	able of
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ⚠No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DOA	Other	26. Place of Dear 4 ☐ Nursing H			□Other (Specif	y)	
ending sath. or: After		Certification: T	27. Manner of Death Y Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М		at es 2⊡No	28d. Describe		occurred Number or Rura	I Route Number,	
DIVISION To the Hospital or Attention 24 hours after deat within 24 hours after deat for the Funeral Director: completely filled in by the			4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec ysician: To the best of my ki				a date and place	City or To	wn, State)			
the Hos in 24 hc the Fun		Medical	(Check only 2 Medical Examone)	iner: On the basis of exami and manner stated.	nation and/or i	nvestigation,	in my opi	nion, death occu	rred at the time	, date and	place, and due to	tne cause(s)	
P S I I I		Σ	29b. Signature and title of certifier			29c.	License	D6223	4		e signed (Month, ptember		
			30. Name and address of person who of Manish Agrawal, M				, #30	00, Kens	ington,	MD 2	20895		
Reg	Stat		31. Date filed (Month, Day, Year)	3. Registrar's Sig	nature	120							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. - Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 11:55 PM September 3, 2009 Orville Twigg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Somerset Manokin Manor Princess Anne 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 X M 2 □ F Director 214-16-4061 04-11-1918 Maryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Experience results. Director 1 Yes 2 No MD Somerset Princess Anne 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11912 Sherree Lane 21853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Aves 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician none Dresser Wayne 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland Lewis Twigg Florence Mae Taylor ပ permit. Pages 1 and 2;
Department of Health an.
Important: If item 27 is m. any injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Twigg/Son 11954 Sherree Lane, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Andrews Episcopal 09-08-2009 Princess Anne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, M00295 11673 Somerset Ave., Princes at Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00295 MD 21853 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Guler disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached for 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 □ Yes 2 No 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A neral Director: A 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only опе)

State

σ

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1415 NATEGAN 32. Regist ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death o Month 2009 AMARIS 12.07 PM TAYLOR 4c. County of Death 4a. Facility Name (If not institution, give street and number) CAMBRIDGE DOKCHESTER DORCHESTER GIENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🔀 F 212-96-3317 29 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 □ No Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 1105 N. Division St 21801 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 XNo Specify: Specify Black 3 ☐ Widowed 4 ☐ Voivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Vista Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Production Laborer Industries 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alton Taylor, Jr. <u>Phycillia M. Coulbourne</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phycillia Hawkins/Mother 1105 N. Division St. Salisbury, MD 21801
lace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Direct Crematory, 9-21-2009 Dover, DE 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility 917 W. Isabella St Bennie Smith 21. Signature of Funeral Service Licensee Funeral Home Salisbury, MD 21801 Approximate Interval Between Onset and Death END STAGE HIV/AIDS Due to (or as a consequence of) MENINGITIS CRYPTOCOCCAL Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑No 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

Physician /Medical Examiner physician and s the burial-trans P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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ir than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Wedfoal Even it act out be no once.

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Be မ Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed certificate this After Director: e Funeral within To the

Division of Vital Records,

Medical State Registrar

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number D 0 0 6 7 4 6 5 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, SEP

Year)

16 2009

300 Byrn street Cambride HD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

		1 - State Registrar		Certificate of L	Death		eg. No.	JUD	GIC
Physicia /Medic		Decedent's Name (First, Middle, Last) James	Larry Winer			2. Date of Deat Month September	Day	Year 2009	3. Time of Death 1559
Examin Funeral Director		4a. Facility Name (If not institution, give street and not have been s	7. Age (In yrs. last bir		Location of Death Iver Sprin If Under 24 Hrs. Hours Min.	g	4c. County Year) 19,1938	Montg 9. Birthpla Counti	ace (State or Fore
a-f show	ctor	Usual Residence of Decedent	10c. City, Towr		Silver Spr	ing		10	d. Inside City Limi
23a or 28	al Director	10e. Street and Number 1014 Rosemere Avenue		10f. Zip Code	20904	1	0g. Citizen of t	What Countr	•
natural", or items 23a or 28a-f show dical Examinar must be notified at	by Funeral	Armed F 1 □ Never Married 2 ■ Married 1 ■ Yes If Yes, G	2 No	13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 🗷 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ce - America ck, White, et	
Theath and Mental Hygiene. Theath and Mental Hygiene. Theath are 23a or 28a-f show other traumatic event, the Medical Evancing must be neithed at	Completed 8	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (16a.	Decedent's Usual Occup, (Give kind of work done of life, DO NOT use retired	during most of wor d)	king	16b. Kind of B	usiness/Indu	ustry
ental Hygier ked other th c event, I'v	Be	12 17. Father's Name (First, Middle, Lest) John Winer		Central Office		ne (First, Middle, I		ommunic	acions
alth and Mental 27 Is marked o r traumatic eve	္မ	19a. Informant's Name/Relationship (Type. Print) Kaete Winer - Wife		. Mailing Address (Street a 1014 Rosemere A		ıral Route Numbe	, City or Town		_
nent of Health ant: If item 27 I ury or other tra		20a. Method of Disposition 1 Burial 2 12 Cremation 3 Removal from 4 Donation 5 Other (Specify)	20b. Place of cemeter	f Disposition (Name of ry, crematory or other place	ce)		20c. Location Brentwo	- City or Tov	vn, State
Department of Department of Important: If it any Injury or conce.		21. Signature of Funeral Service Licensee		22. Name and Addres Hines-Rinald 11800 New Ha	i Funeral	Home, Inc. enue, Silv	er Sprin	g, Mary	land 2090
hysician	0.3	Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final	caused the death. Do i each line.	not enter the mode of dyin	ng, such as cardiad	or respiratory arr	est,		Approximate Interval Between
Medical xaminer	sal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events a. Due to	Respiratory Fa (or as a consequence Pneumonia (or as a consequence (or as a consequence	of): of):					Onset and Death 4 days 6 days
watending physician and and cruse as the burlat-transit	edical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	(or as a consequence of or as a consequence or a consequence or a consequence or a consequence of or a consequence or a cons	of): of):				ate of delive	Onset and Death 4 days 6 days
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ex Section 2 is a second of the attending physician and sage 2 should be detached for use as the burial-transit of section 2 is second of the section 2 is sectio	Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty that initiated events resulting in death) Last Due to d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to decede the cause of the conditions contributing to decede the cause of the cause	vor as a consequence of or as a consequence or a consequence or a consequence or a consequence or a consequence of	of): of): of): 3	en in Part I.	1 🖪 Y	bacco use con es 2 \(\sum \) No in 24b. sy med? 2 \(\sum \) No	ate of deliver onth attribute to the square of the square	Onset and Death 4 days 6 days Ty Day Year e cause of death ably 4 \[\] Unkn osy findings avail npletion of cause
death. ctor; After this certificate has been signed by the attending physician and g ctor; After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit g b	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty that initiated events resulting in death) Last LEF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to the carcinoma Lung Previous Pneumonectomy Chronic Obstructive Lung D 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 1 2 2 2 2 2 2 2 2	icor as a consequence of cor ect or as a consequence or	of): en in Part I. 26. Place of Dealer: 4 \(\) Nursing H	1 🗷 Y 24a. Was a autopi perfor 1 □ Yes ath (Check only or tome 5 □ Resid 28d. Describe h	M bacco use con es 2 □ No in sy med? 2 ₺ No ence 6 □ Ot ow injury occu	ate of deliver onth atribute to the second of the second	Onset and Death 4 days 6 days 6 days Fy Day Year e cause of death abiy 4 \(\) Unkr osy findings avaii npletion of cause 2 \(\) No	
death. ctor; After this certificate has been signed by the attending physician and g ctor; After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit g b	Certification: To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to or Carcinoma Lung Previous Pneumonectomy Chronic Obstructive Lung D 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Carcinoma Investigation Suicide Could not be determined 28e. Place built 29a. Certifier (Check only) [29a. Certifier 1 Certifying Physician: To the could not be determined Could not be determined 29a. Certifier Check only Check only Could not he determined Cou	isease Inpatient 2 ER/Ot and Injury anth, Day, Year) In (or as a consequence of the consequence of pregnancy of the consequence of the consequenc	of): en in Part I. 26. Place of Deceer: 4 Nursing Fry at k? Yes 2 No	1 🗷 Y. 24a. Was a autop: perfor 1 □ Yes ath (Check only or tome 5 □ Resid 28d. Describe h 28f. Location (S City or Tow	bacco use con es 2 No nn 24b. sy med? 2 No ence 6 Ot ow injury occu treet and Num n, State) cause(s) and n	ate of delivered autoprior to condeath? The condeath of the c	Onset and Death 4 days 6 days 6 days Fry Year e cause of death ably 4 Unkn by findings avail appletion of cause 2 No Route Number, tated.	
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to or Carcinoma Lung Previous Pneumonectomy Chronic Obstructive Lung D 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Carcinoma Investigation Suicide Could not be determined 28e. Place built 29a. Certifier (Check only) [29a. Certifier 1 Certifying Physician: To the could not be determined Could not be determined 29a. Certifier Check only Check only Could not he determined Cou	icor as a consequence of or as a consequence of the or as a consequence of death nown or as a consequence of or as a consequence of or as a consequence o	of): en in Part I. 26. Place of Decer: 4 \(\text{Nursing F} \) y at k? Yes 2 \(\text{No} \) me, date end plac appinion, death occurs.	1 🗷 Y. 24a. Was a autoport of the control of the	M bacco use con es 2 □ No es 2 □ No es 2 ■ No ence 6 □ Ot ow injury occu treet and Num n, State) cause(s) and n date and place	ate of deliverionth atribute to the stribute to the stribute to condeath? 1 Yes ther (Specify ried) manner as stributer or Rural manner as stributer of Month, 1	Onset and Death 4 days 6 days 6 days Fry Day Year e cause of death abily 4 \(\) Unknown one of cause 2 \(\) No Route Number, tated. the cause(s)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 7:45 P **Physician** 09 13 2009 SHIRLEY THOMAS WYATT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON TALBOT TALBOT HOSPICE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 🗶 F 07/25/1920 MARYLAND 89 Director <u> 214-10-0660</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 □Yes 2 No Director EASTON MD TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21601 USA 27948 OAKLANDS CIRCLE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JEWELRY STORE 12 OWNER nd 2 should be filed with and Mental Hygier 27 is marked other the traumatic event, Its 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES ODIE THOMAS WILLIE DORSEY PRITCHETT ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau 1 and 2 s Health a 529 BAY GREEN DRIVE, ARNOLD, MD BARBARA BROGAN/DAUGHTER 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 09/17/2009 EASTON, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MIC 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End ta luve O Years cna disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Coopsideration of Examiner If any, leading to immedia cause. Enter Underlying Cause Or injury that initiated events resulting in death) Last requires that the death certificate be executed physician and s the burial-tran and Due to (or as a consequence of) Box 68760. Physician/Medical as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the a Ö ۵. s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate | 1 ☐ Yes 2 ☐ No 2 No 1 □Yes Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) HOSPICE Hospital: 1 Yes 2 → 6 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pleasin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce mi

Registrar

DHMH 17 Rev 1/2001

State

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Cynwood Dr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 5 2009

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32 Registrar's Signatur

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31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar FH Certificate of Death Reg. No. Amended 09/15/09 pha TCHD, 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 12 **Physician** 2009 Sept 12:30 ₽M Gladys Irene Wagner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Talbot Genesis HealthCare -Easton The Pines Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2√2 F 82 Baltimore Md 10-23-1926 Director 214**-**22-6775 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examiner must be notified at 1 X Yes 2 □ No Md Talbot Director Easton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17 Downing Street 21601 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 □Yes 2√□No Specify. White White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waqner Elementary/Secondary (0-12) College (1-4or 5+) Stone Company 11 Stenographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Meyer Gladys Irene Martin ို Gladys 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glenn Craig Wagner husband 17 Downing Street, Easton, Md. 21601 20b. Place of Disposition (Name of cemetery, crematory or other place)
MidShore Cremation 9-14-2009 Cambridge, Md. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. Carroll Hurley Funeral Home, P.O. Box 518, St. Michaels, Md. 21. Signature of Funeral Service Licenses PC 21663 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (as a consequence of): Examiner allure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed 1000 ling physician and e as the burial-trans Division of Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending I should be detached for use as IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 pronths? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 autopsy performe 2 🗆 No 1 □ Yes 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes 2 X No Certification: To this s after death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Injury 5 ☐ Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide vithin 24 hours are
To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier PPa Name and address of person who completed cause of death (Item 23a) (Type, Print) ANE DUTCHMANS 610 (ROWLEY

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SEP 15

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10f Per State 896 Mary 109 eptertment of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 7:10 PM enser 14,209 Clyde U. Washington /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Doctor's Community Hospital Lanham 8. Date of Birth (Month, Day, Year) 06/14/1920 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 X M 2 □ F Yrs. South Carolina 577-28-3666 Director Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f shov 1x Yes 2 □ No Director Maryland Takoma Park Prince George 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō 20746 **20912** 6731 New Hampshire Ave., Apt. 807W 23a United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: African American ₫ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5th Bartender Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Washington Rosena McCutchen ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn W. Newsome/ Daughter 3431 Wood Creek Drive Suitland, Md. 20b. Place of Disposition (Name of Resurrection Cemetery 20c. Location - City or Town, State 20a. Method of Disposition September permit. Pages
Department of
Important: If it
any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 19, 2009 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign ure of Funeral Service Licen ee 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, er complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate C (Final disease or condition resulting in death) Physician ardiores Pirator /Medical Due to (or as a consequence of): Examiner neumor Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): and the burial-tran physician P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 I Inknown 9 Unknown by s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has page 2 autopsy performe 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ≯ filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sepember 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CALAF P.O. Box 297 GKEEWBELT, MD M.O. 31. Date filed (Month, Day, Yea SEP 2 1 2009 32. Registrar's Sign State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 6.00 A Regina E. Whitaker /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GLEN BURNIE ANNE BALTIMORE WASHINGTON MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🟋 F 212-72-2361 2-19-1958 **Director** MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Deparment of Health and Mental Hygiene. Important: if item 23a or 28a-f show any injury or other traumatic event, the Medical Ext. of the Little Let Louisided. 1X Yes 2 No Director MD Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1405 Flagstone Court 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐X0 If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify.Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Processer USDA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be ျှ Marvin Purnell <u>Ernestine Bivens</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Tony Whitaker/Husband</u> 1405 Flagstone Court, Severn, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-19-2009 Pocomoke, MD Trinity UMC of Funera 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. En the disc ase, or complications that caused the shock, or heard ailure. List only one cause on each line. Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, STACE END **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): SEPCIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injury that in the cause of the cau Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No this certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To s after death.

I Director: After this of in by the funeral d 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who complited cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day, Year)

212	Registrar 1. Decedent's Name (First, Middle, La	st)				2. Date of De	Reg. No.	Year	3. Time of Death
an cai	CHARLES HOWARI		ſr.				mber 23	2009	8:50 PM
ner	4a. Facility Name (If not institution, giv				or Location of Dea	ith	4c. Count		
	Morningside House 5. Social Security Number 6. S		(In yrs. last birtl	Lau		S. 8 Date of Ric			orge's lace (State or Foreig
		IDXM 2□F		rs. Months Days			ay, Year) 3, 1916	Coun	itry) [inia
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_	10a. State 10b. County		10c. City, Town	or Location				10	0d. Inside City Limits
by Funeral Director	MD Montgo	omery	Ash						1 □Yes 2 🟋No
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eral	17813 Striley				20861	O	USA		an Indian
Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		 Was Decedent of If Yes, specify Cu 	ban, Mexican, Pue	rto Rican, etc.)	0- 14. Ha Bla	ce - Americ ck, White, e	
چ	3 XWidowed 4 □ Divorced	1 ⊠Yes 2 □ N If Yes, Give Year or Dates:		1 □Yes 2 🖾 No	Specify:		Speci	_{fy:} Whi	.te
ted	15. Decedent's Ed	ducation	16a.	Decedent's Usual Occu	pation	46	16b. Kind of E	lusiness/Inc	dustry
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Be	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle		ne)	
은	Charles Howard	Angel, Sr					Saul		
	19a. Informant's Name/Relationship (Mailing Address (Stree					Code)
	Clifford D. Angel	1/5011		7813 Strile Disposition (Name of crematory or other pla		ASNTOr Date	20c. Location	0861 - City or To	wn, State
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	4 ☐ Donation 5 ☐ Other (Specit 21. Signature of Funeral Service Licer		West A	22. Name and Addi					
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	resulting in deathy East	Due to (or as a	consequence o	n):					
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by PI	Part II. Other significant conditions of	contributing to death bu	t not resulting in	the underlying cause g	iven in Part I.	23e. Did	tobacco use cor	tribute to th	ne cause of death?
엉	Dysphagia					. 10	Yes 2∑No	3 ☐ Prob	ably 4 🗌 Unknow
plet	Aspiration	Terminal				24a. Was			psy findings availabl
Completed						auto perfo	ormed? 2 X No	death?	mpletion of cause of 2XINo
BeC	25. Was case referred to medical examiner?				26. Place of De	eath (Check only			
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မ	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	y 28b. Ti Year) In	jury Wa	ork?	28d. Describe	how injury occu	rred	
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cation: To	3 □ Suicide 6 □ Could not be	28e. Place of Injur	y - At home, fari (Specify)	n, street, factory, office			(Street and Num wn, State)	<i>ber</i> o <i>r Rur</i> a	I Route Number,
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I Certification: To	4 ☐ Homicide determined		f my knowledge	death occurred at the	time, date and pla	on and due to the			
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Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

09-07225 Darnell Allen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	Reg. N	o	0 0155
Physicia	n/	1. Decedent's Name (First, Middle,Last)	ate of Death onth Day	/ Year	3 Time of Death 1023 hrs
ledical Examir		Dariter miles	eptember 15	5, 2009 4c. County of Death	
	Н	4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital 4b. City, Town, or Location of Death Takoma Park		Montgomery	·
Funoral		Tracking to Francisco Fran	Date of Birth (M	M/DD/YYYY) 9. Bir	thplace (State or Foreign
Funeral Director		1 X M 2 F 42 Yrs. Months Days Hours Min. Ju	une 9,	Co	ountry)
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		MD Prince George's Hyattsville			1 Yes 2 No
/aryland 28a-f show 1 at once.	Scto	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Cou	ntry?
the Man or 2	Director	4922 Lasalle Road 20781		USA	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Them 27 is marked other than "natural", or items 23a or 28a-f she or traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Link of the Specify Cuban, Mexican, Puerto Ricary)	Yes or No- in, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
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Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Signat of Fune Service Licens nald S. Director 22. Name and Address of Facility State Anatomy Board	655 W.	Baltimore	e Street
	4	Baltimore, MD 21201 23a. Lart I. Enter the discusser or emplications that caused the death. Do not enter the mode of dying, such as cardiac or responses.			Approximate Interval
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED AMENDED 23a,27,perME, g896 10/5/09 TT			
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e time, date and	d place, and due to	the cause(s)
To Wij	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed (A	
		famoli Gulhall MD O.C.M.E.	15	September 16,	2009
7 **		30. Name and address of person who completed cause of death (Item 23a)			
		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
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Regis	ueil				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Defedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, onLocation of Death Examiner USIN H, mp 8. Date of Birth last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 2.23a or 28a-f show important: If item 27 is marked other than "natural", or items 2.3a or 28a-f show yor jujury or other traumatic event, the Medical Examination and be motified at once. 14. more 1 ☐ Yes 2 XNo Director 10g. Citizen of What Funeral Was Decedent of Hispanic Orgin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 72 hours after 1 Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation College (1-4or 5+) LIMBEI 17. Father's Name (First, Middle, Last Be Pages 1 and 2 should be ပ mber or Rugal **Flo**ute Numbe<u>r. C</u>ity or Town, State, Zip,Code) Baltimore, 20a. Method of Disposition Location - City of Town, State 3 Removal from State 2 Cremation 5 ☐ Other (Specify) f Funeral Service Licensee gnatur pproximate terval Between nset and Death (1. Enter the disease, or complications that caused the mock, or hear failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, I mediate Cause (Final Lease or condition resulting in death) **Physician** mon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and the burial-transit Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions con to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ emy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed desiens 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performe certificate 2 □ No 1 ☐ Yes 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 🗌 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cg mp erson who completed cause of death (Item 23)) (Type, Print) 3 2/208

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) OCT 0 2 2009

Registrar's Signatu

amend #4b&c Per Phy G896 10/13/09 JH

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27,2009 Year Month September Physician 3:55 SHELLEY BLOW ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Prince George's** Examiner Future Care Pineview Nursing Home Millersville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 12–08–1924 Birthplace (State or Foreign Country) **Funeral** 1**™** M 2□ F Months Days Hours Min 245-20-8042 Director 74 Greenville, NC Usual Residence of Decedent the Maryland la or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md Prince George's Oxon Hill Director 1 √ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or inny or other traumatic event, Ite Medical Examination must be a 1102 Lindsay Road 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. <u>م</u> Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lontas Blow 2 Beauhah Lang 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Price - Daughter 5106 Tarpin Court, Waldorf, Md 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot October 3,2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Teel Family Cemetery Greenville, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease Immediate Cause (Final disease or condition resulting in death) **Physician** YPAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any leading to immune cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ icate has been siç page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate tal or Attending Physician: Tirs after death.
al Director: After this certificate led in by the funeral director, pa Division of Vital 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Peath (Check only one) examiner? Other: 4 vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 462 Name and address of person who completed cause of 31. Dat filed (Month, Day, Year)
OCT 0 2 2009 State Registrar

Physicia /Medic Examin

Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and peopletely filled in by the funeral director, page 2 should be detached for use as the burial-transit

- State Alliend I Leilis 2.3 a. Registrar 1. Decedent's Name (First, Middle, Last)			<u></u>		2. Date of Dea		Year	3. Time of Death
Leland	C.		Bradley		July	29	, 2009	12:28A
a. Facility Name (If not institution, give street a			_	r Location of Death			County of Dea	
1304 Wine Spring Lan Social Security Number 6. Sex		. last birthday)	Towson If Under 1 Year	If Under 24 Hrs.	8 Date of Birt		altimor	thplace (State or Fore
565-32-7328 1X M 2		Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day Aug • 1	Year) 1,19	28 Ca1	untry) ifornia
Usual Residence of Decedent Oa. State 10b. County	10c C	ity, Town or Lo	cation					10d. Inside City Lim
MD Anne Arunde		Linth						1 □ Yes 2 🔯 I
0e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	ountry?
200 Exeter Court			21090			U.S	.A.	
	is Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
1 Never Married 2 Married 1X]Yes 2 ∏ No es, Give ar or Dates:		1 □ Yes 2 No	Specify:	,		Specify: Wh	
15. Decedent's Education (Specify only highest grade comp.	oleted)	16a. Dece	dent's Usual Occup	eation during most of worki	ing	16b. Kii	nd of Business	/Industry
Elementary/Secondary (0-12) Col	llege (1-4or 5+) 5-1-	Engin		i) -		Mec	hanical	Engineer
7. Father's Name (First, Middle, Last)		18+11		18. Mother's Name	(First, Middle,			202001
Floyd Edison Bradley				Helen Do				
9a. Informant's Name/Relationship (Type. Prir	nt)	19b. Mailir	ng Address (Street	and Number or Run	al Route Numbe	er, City o	r Town, State,	Zip Code)
Mrs Pamela J. Trapp/			-	ng Lane To	owson, 1			· -
0a. Method of Disposition ; 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other plac				cation - City or	
4 □ Donation 5 □ Other (Specify)			Cemetery				esville	·
Signature of Funeral Service Licensee	M0122	ا ر		ss of Facility ${ t Sin}$ ${ t Sin}$				remation e, MD 210
23a. Part 1. Enler the disease, a complications shock, or heart failure. Hist only one caus	-	-						Approximate Interval Between
mmediate Cause (Final disease or condition	Pneumonia							Onset and Death
resulting in death)	Due to (or as a consec	quence of):		CARIO APPROVED BY	.11	-10	i,	
Sequentially list conditions, b.	Stroke	and the			WEXEN EXPONE	MEL		2 years
any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events c	Trauma	quones on		PROVED BY	Mirro			2 years
	Due to (or as a consec	quence of):	CERTIF	CKUCK				
d				•				
F FEMALE:			W7 0.3			T	-	
23c. If ye in the past 12 months?	es, outcome of pregn Live birth 2 Fet Pregnant at time of Unknown	al death 3	Ectopic pregnanc Other <i>(sp</i> ec <i>ify)</i>	у		2	23d. Date of de Month	livery Day Ye ar
art II. Other significant conditions contributin	ng to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco u	ise contribute t	o the cause of death?
N/A					1 □ Y	es 2	X No 3□P	robably 4 🗆 Unkno
					24a. Was a			utopsy findings availa
					autop perfor 1 □ Yes		death?	completion of cause
5. Was case referred to medical examiner?				26. Place of Death				Daughte
1 XYes ₹X No Hospital:	1 Inpatient 2	· · · · · · · · · · · · · · · · · · ·		4 LI Nursing Ho				ecify)Residen
	Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl	ί?	28d. Describe h Subject			head wit
7. Manner of Death 28a.		10:06		Yes 2X No	hammer			
7. Manner of Death 1. Natural 5 ☐ Pending and Accident investigation of Could not be	9/16/2008 Place of Injury - At h	nome farm etr	July, ractory, Utility		City or Tow	n, State,	200 Ex	ural Route Number, eter Cour
7. Manner of Death 1. Natural 5 ☐ Pending and Accident investigation of Could not be	. Place of Injury - At h building, etc. (Speci	nome, farm, stro ify)			Linthia	cum - '	MU	
7. Manner of Death Tan Natural 5 Pending 1 Pendi	Place of Injury - At h building, etc. (Speci me To the best of my kn n the basis of examin	owledge death	occurred at the tir	me date and place	Linthic and due to the red at the time,	cause(s)	and manner a	s stated. e to the cause(s)
7. Manner of Death The Natural and Park Cident	Place of Injury - At h building, etc. (Specime	owledge death	occurred at the tir	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner a	e to the cause(s)
7. Manner of Death Table Natural S Pending Investigation OS Suicide A Homicide Home	Place of Injury - At h building, etc. (Speci me To the best of my kn n the basis of examin	owledge death	n occurred at the tirvestigation, in my o	me, date and place, pinion, death occur e number	and due to the red at the time,	cause(s) date and	and manner a place, and du	e to the cause(s)
7. Manner of Death Table Natural S Pending Investigation OS Suicide Getermined Could not be determined Hot Paa. Certifier (Check only one) Certifying Physician: 2 Medical Examiner: Or and	Place of Injury - At h building, etc. (Specime To the best of my kn the basis of examin d manner stated.	owledge, death ation and/or in	o occurred at the tirvestigation, in my o	me, date and place, pinion, death occurrence enumber	and due to the red at the time,	cause(s) date and 29d. Dat	and manner at place, and due to signed (Month	e to the cause(s) th, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** ranc 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hmor If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 M 2 □ F 127-22-3258 tanama **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If Medical Examinations and injury or other traumatic event, If who died Examinations and injury or other traumatic event, If who died it is a conditional and injury or other traumatic event, If who died Examinations are required. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director altimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number do by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 ☐Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 📉 No ac 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) erchant 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be un Know ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltomore Son Kd Miquel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 10/1/09 Baltimore, 4 Donation 5 Other (Specify) rematory 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility MD 21207 4600 Heights Balto. 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Vascu Atheroscle Fears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 signed by the attending physician be detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2/X/No 1 ☐Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1/⊠Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D32158

State Registrar

DHMH 17 Rev 1/2001

821 N.

Registrar's Signature

St, Ste 407

Balti moces

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary Dorothy Basil 2009 October /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Days 1 □ M 2 □ F 213-03-9543 MD pril 15, 1920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant: if Item 27 is marked other than "natural", or items 23a or 28a-1 shov injury or other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2√2 No Director Bel Air MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21014 1202 Grafton Shop Road Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or any injury or other traumatic event any injury or other traumatic event Black, White, etc. 1 □Yes 2□No If Yes, GiveXX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3€Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Co. Director Coordinator 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Dieter James Meehan ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Son 1202 Grafton Rd., Bel Air, Md. Wayne Basil 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/05/2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 22. Name and Address of FacilitySchimunek Funeral Home of Bel Air 610 W. MacPhail Rd., Bel Air, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition **Physician** a SEVERE SEPSIS resulting in death) 1 /Medical Due to (or as a consequence of) Examiner b. A CUTE COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit CLOSTRIDIUM DIFFICILE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 ☐ Yes 2 DoNo
9 ☐ Unknown 4 Pregnant at time of death 5 ☐ Other (specify) tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by COPD HYPERLIPIDEMIA 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ACUTE RENAL FAILURE 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled to the control of the con P.O. Box 68760 Division of Vital Records,

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State Registrar

completely

29a. Certifier

(Check only

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29b. Signature and title of certifie

DHMH 17 Rev 1/200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

622 S. UNION AVE, HAVRE DE GRACE

29c. License number

D45344

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene UUS For

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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1. Decedent's Nam	ne (First, Middi	le, Last)	-							of Death		14	3. Time of Death
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		n, give street and nu	ımher¹	·	4h Cib	Town or	Location	of Death		-, -,		ty of Death	
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5. Social Security N		6. Sex 1 M 2 □ F		yrs. last birtho	Months	r 1 Year Days	If Under Hours	Min.	8. Date	of Birth	Year)	9. Birth	place (State or Foreig intry) Tand
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Usual Residence of	· · · · · · · · · · · · · · · · · · ·		100	Oit. Town	. Laundiau								10d. Inside City Limits
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MD	Montgo	omery	0	lney									1 Yes 2 □ No
10e. Street and Nu	mber				10f. Z	ip Code				10	g. Citizen of	f What Cou	intry?
19113 B1	oomfie:	ld Rd.			20	832				1	United	l Stat	tes
11. Marital Status		12. Was Dec	edent Ever i	in U.S.	I3. Was Dece	edent of H	ispanic Or	rigin? (Sp	ecify Yes	s or No-	14. Ra	ace - Ameri	ican Indian,
1 Never Marr	ried Mar	Armed F	orces?		I3. Was Dece If Yes, spe		an, Mexica	n, Puerto	Rican, e	etc.)	BI	ack, White,	etc.
3 Widowed		I If Yes' G	2 No	69 171	1 ☐ Yes	2 No	Specify	7			Spec	ify: V	White
o El midomod			Dates. 17		ecedent's Us	ual Occum	ation			11.1	6b. Kind of	Rusiness/Ir	ndustry
(Spe	cify only highe	nt's Education est grade completed))	(G	ive kind of w fe. DO NOT i	ork done	during mos	st of work	ing		OD. IKING OF	Dusiness, ii	loustry
Elementary/Seco	ondary (0-12)	College ((1-4or 5+)	l	earms	_					Federa	al Gov	vernment
	(F: + 14:11)	4		1.11	carms	IIIGU			- /Fi4				
17. Father's Name			ua.					ers Name lian			laiden Surna or	une)	
John Dou	gras b	radbury Si	L •	т					T.T.	761111			
19a. Informant's N	lame/Relations	ship (Type. Print)		19b. M	ailing Addres	s (Street	and Numb	er or Rur	al Route	Number,	City or Tow	n, State, Zi	ip Code)
Sally Br	adbury-	-Wife		191	13 Blo	omfi	eld R	d. 0	1ney	MD	20832		
20a. Method of Dis	٠.		20	0b. Place of D	sposition (Na	ame of	e)		Date		0c. Location	- City or T	own, State
1 ☐ Burial 2° 4 ☐ Donation	Cremation	3 🗖 Removal from		Chesape				09/3	0/20	$ 09 _{B}$	eltsvi	ille,	MD
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21. Signature di 1	# 7	Liversee	Mocs	332				•					
Service	MOW	turne	m			.,						oring	MD 20910
23a, Part 1. Enfort	the disease, or art failure. List	r complications that t only one cause on	caused the o	death. Do not	enter the mo	de of dyir	ng, such as	s cardiac	or respir	atory arre	est,		Approximate Interval Between
Immediate Cause		· D											
diagram or condition	~~	T A A I	C'DFA-	Jan C	NAMED								Onset and Death
disease or condition resulting in death)	on	a. TAN	CREA-		ANCER							-	Oriset and Death
disease or condition	on	a. Due to	CREA-	nsequence of):									Oriset and Death
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State of Maryland / Department of Health and Mental Hygiene (1) - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard September Boyd 12:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4533 Hornbeam Drive Rockville Montgomery . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State (Month, Day, Year) Pecember 12, 1926 New Jersey 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 152-22-2136 82 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show suffiged at Maryland 1 ☐ Yes 2 X No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 2 any lipity or other traumatic event, the Muchael Ferratorials on 2 any lipity. 4533 Hornbeam Drive 20853 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No WWII altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify. Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Program Manager Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winfield Dayton 0'Callahan Elizabeth 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen A. Boyd / Daughter 723 Rosin Drive, Chestertown, Maryland 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date October 3, 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischemic Cardiomyopathy years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 5 years Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Diabetes Mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b 2 X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this e Hospital or Attending Pi 24 hours after death. e Funeral Director: After the felely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 29a, Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D33443 September 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Pollack, M.D. 1201 Seven Locks Road, Rockville, Maryland 20854

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Ma	ryland / Depa <i>Cer</i>	rtificate of l		Reg	. No. 2 A A G	31558
	Physicia		1. Decedent's Name (First, Middle, Last) Richard K. Brown,	Jr.			2. Date of Death Month September	r 28, 2009	3. Time of Death 6:25 A M
and a	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Bethes	Location of Death		4c. County of Death	
	Funeral		Suburban Hospital 5. Social Security Number 217-34-0037 6. Sex 1 M № 2□ F 7	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9 Birth	nplace (State or Foreign intry) L Virginia
	Director		Usual Residence of Decedent	10c. City, Town or Loc	- tion		,		10d. Inside City Limits
	Maryla f shov	tor	10a. State 10b. County Maryland Montgomery	Potomac	CallOll				1 ∐Yes 2 X No
	or 28a	Director	10e. Street and Number		10f. Zip Code			j. Citizen of What Cou	-
	23a o		9104 Paddock Lane		208			nited Star	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventine must be rutified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E-Armed Forces? 1 ☐ Yes 2 ☑ No 1f Yes, Give Year or Dates:	0	Was Decedent of H f Yes, specify Cuba 1 □Yes 2ሺ No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	ation during most of work d)	ing 16	6b. Kind of Business/	ndustry
212	2 should be filed within 1 h and Mental Hyglene. 7 Is marked other than " traumatic event, the Mec	dwo	Elementary/Secondary (0-12) College (1-4or 5+ 5+	-)	ronic Eng			ederal Go	vernment
	e filed tal Hyg d othe	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma		
Maryland	ould by Ment	ပ္	Richard K. Brown	405 14-10-	- Add (Ctroot	France		On City or Town, State, Z	Zin Code)
Mai	alth and 2 st		19a. Informant's Name/Relationship (Type. Print) Emma L. Brown / Wife					ryland 208	
Baltimore,	Page nent c		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entombment	20b. Place of Dispo- cemetery, cren Gate of Hear		,	per l,	oc. Location - City or large	Town, State
Balt	permit. Page Department Important: It any Injury o		21. Signature of Funeral Service Licensee Miguel Commission Medical Service Licensee	01305 Ro 75	Name and Addre bert A. Pur 57 Wiscons:	ss of Facility nphrey Fune in Avenue,	ral Home/Be Bethesda, M	ethesda-Chev Maryland 2081	y Chase, Inc. 4-3501
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)		er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed as the speed signed by the affending physician and agge 2 should be detached for use as the buriat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underphilip Cause (Disease or injury that initiated events	a consequence of):					2 weeks
O. Box	at the death certific by the aftending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of the past 12 months? 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	☐ Ectopic pregnand ☐ Other (specify) _	ey		23d. Date of del Month	ivery Day Year
rds, P.	quires that n signed b ald be deta	þ	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
of Vital Records,	; The law requir cate has been si page 2 should I	Completed					24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
Vita	sician certifi irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	nt 2 ☐ ER/Outpatier	nt 3 🗆 DOA Oth	or:	th (Check only one) nce 6 ☐ Other (Spe	acifu)
on of	Attending Physician; The Ir death. ector: After this certificate hiby the funeral director, page	tion: To	27. Manner of Death 1 Natural 5 Pending (Month, Day	y 28b. Time o	of 28c. Inju	4 LI Nuising F	28d. Describe how		Luiy)
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	a El accident	I iry - At home, farm, str . (Specify)			28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	24 hours Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or in	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	e, and due to the ca arred at the time, da	tuse(s) and manner a te and place, and due	s stated. e to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier		29c. Licens		29	d. Date signed (Mont	th, Day, Year)
	00 1		N MD			XX66990		10/1/09	
	JU V			ckledge Dr	rive, Sui	te 4100,	Bethesda	, Maryland	20817
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registra	ar's Signature	adel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2009 September 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium 8. Date of Birth (Month, Day, Yea June 26, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Year) 1923 1 M 2 X F Hours Tennessee 86 10c. City, Town or Location 10b. County Baltimore Baltimore 10g. Citizen of What Country? USA 21209 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Black White etc 1 ☐ Yes 2 💢 No Specify: white Specify: Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation

For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 4:19 AM M Eunice Butler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Stella Maris Hospice 9. Birthplace (State or Foreign **Funeral** Director 411-22-0794 Usual Residence of Decedent 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No 10e. Street and Number Completed by Funeral 7301 Travertine Drive #205 1 Never Married 2 Married 3 👿 Widowed 4 🗆 Divorced any injury or other traumatic event, the Medical 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) addiction counselor State of Maryland 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Bessie Montgomery William Cleveland Freshour 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7301 Travertine Drive #295 Baltimore, MD 2109 19a. Informant's Name/Relationship (Type, Print) Susan doyle/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ronald S Wash State Anatomy Board 655 W. Baltimore Street Director 222 Baltimore, MD 21201 23a. Part 1. Enter the diffease, in complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to introducts cause. Enter Underlying Examiner Dua to for sele considuring of Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 4 L Pregnam 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 🗆 Probably 4 🗆 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Xcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number

Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Ö Records, In the Function and the death.

To the Euneral Director. After this certificate has been in the function of the function page 2 should **Division of Vital**

28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a.4 shw

21215-0036

Maryland

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ETEMBER 29 2009 Helen Boniarski /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** BURNIE CIL ANME SALTIMORE WASHINGTON MEDICAL If Under 1 Year | If Months | Days | If 8. Date of Birth (Month Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗡 F Maryland 90 212-09-6891 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🙀 No Director Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1241 Halstead Road 21234 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 💢 No white 1 ☐Yes 2 XNo Specify ģ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Can Co. 12 Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Parkosz Leopold Twardowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) grand 616 George Avenue; Baltimore, MD 21221 Ronald J. Boniarski, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation S ☐ Other (Specify) 3 Removal from State Holy Rosary Cemetery |10/3/09 Dundalk, MD 22. Name and Address of Facility 21. Signature of F 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 m of ths?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 Nio 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

Box 68760. requires that the death certificate attending nse for P.0. detached þ Records. has director, page 2 certificate Division of Vital the Hospital or Attending Physician: this funeral After t within 24 hours after death. To the Funeral Director: A the filled in by completely

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Baltimore, Maryland 21215-0036

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traumatic event, the Medical Examinar must be notified at

Registrar

State

20d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

DI Howital Wive

and

29b. Sign

Registrar's Signature

		1	For State Registrar	State of Ma	aryland				ealth a Death			giene Reg. No.	009	3 5 6
			Decedent's Name (First, Middle, Las	t)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia		Norma	G.			Carv	er			09	29	2009	8:30p. ^M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	_				Location o			4c. C	ounty of Death	
	LAGITIII		Blue Point Nur	sing Home	е		-		more					
	Funeral Director		5. Social Security Number 6. S 216-34-7717 1	9x 7. Age □ M 2 欠 F	e (In yrs. las 69	t birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bid (Month, Da 01 25	y, Year)	Cou	place (State or Foreigi ntry) MD
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he N	289-f	ect	MD NA 10e. Street and Number		20		10f. Zip	Code				10g. Citize	en of What Cou	intry?
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figurea	Department Important: If any injury or once.		21. Signature of Fungal Service Licer	K. Jmes)		4300	Wak		Ave			ce, Md	21215
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	to the hospital or Attenuary Prysicians, within 24 hours alter death. To this Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not l 4 Homicide determined	289. Place of in	njury - At hon etc. (Specify)	ne, farm, st	reet, facto	ry, office	49-1			(Street and own, State		ural Route Number,
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1	V		30. Name and ad ress, 1 erson who KATEN Dr. WELVETT	completed cause of	death (Item	23a) (Type	n, Print)					-/-	-1	
	St	ate	31. Date filed (Month, Day, Year)	32 Regist	trar's Signati		a Mad	,						

		1	For State Registrar	State of Ma	•		rtment of H		Re	g. No. 2 0 0 .9	31562
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/Me	dical	-	a. Facility Name (If not institution, give		arr		4b. City, Town, or	Location of Death	October	4c. County of Death	
Exan	niner		230 St. Mark V				•	minster		Carro	
Funer Direct			. Social Security Number 6. Se		(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Jane Day	Yang 30 9. Birth Co.	place (State or Foreign
and			Jsual Residence of Decedent 0a, State 10b. County		10c. City, Towr	or Loc	ation				10d. Inside City Limits
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with the a or 28a	Directo		0e. Street and Number 230 St. Mark Way				10f. Zip Code	58	10	g. Citizen of What Cou	intry?
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I or Attend after death Director:		Certification; 10	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			arm, str	eet, factory, office	162 5 110	28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
To the Hospital or Attenwithin 24 hours after deatl of the Funeral Director:		medical Ce	29a. Certifier (Check only one) Check only one) Check only one)	nysician: To the best on the basis or and manner sta	f examination a	ge, deatl and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occi	e, and due to the curred at the time, c	cause(s) and manner a late and place, and du	s stated. e to the cause(s)
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•			30. Name and address of person who Ris Christ OA No. 231. Date filed (Month, Day, Year)	completed cause of d	leath (Item 23a)	(Type,	Print)	ti In	1 mas	Jum MID	7.1093
Red	State		31. Date filed (Month, Day, Year)	32. Registro	ar's Signature	· · ·	14/20	yeu			- 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number
461-25-918
Usual Residence of Decedent 7. Age (In yrs. last birthday, If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Hours Days 1**⊠**M 2□F Director 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. CO NOT use retired)

[3 V S I V E S OUN L 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STEEL 12 is marked other 17. Father's Name (First, Middle, Last) Be DOO CHO1 Pages 1 and 2 should be ment of Health and Mental ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AYE. SILVER SPRING.MD Department of Health a Important: If Item 27 is any injury or other trau once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/3/09 WORBECIL MEMPK 22. Name and Address of Facility HOWELL FUNERAL 21. Signature of Empleral Service Lic GUILFORD Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I Records, þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 2 2 No After this certificate 1 ☐ Yes I□Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? 27. Manner of Death To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ompletely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of erson who compared cause of death (Item 23a) 8101 PAINICEPHILLI

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 810 M se 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ctr. Burnine med Olex f Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Year NEW / Months Hours Min 1 **⊠** M 2 □ F Director YOR/L Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Predict Exemplate must be nothing any Injury or other traumatic event, I'm Predict Exemplate must be nothing at 10b 10a. State County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No TrINCE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4114 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. à Specify: 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be CHIREAU ROGER mook မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HIREAL HThE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State METRO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euriferal Service Licensee Home 20199 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** terioscleretie /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-tra Due to (or a a consequence P.O. Box 68760 signed by the attending physician the Hospital or Attending Physician; The law requires that the death certificete be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To the funeral 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ON

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ne and address of person who complete

Dies J. Janes

ause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month October 1, 1:35 AM ^Y2009 Physician/ Francis Carmine Caggiano Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1**X**M 2 □ F 81 Months Days Hours Min. Sep 12, Year 928 Newy)York Director 064-22-9707 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21206 6703 Beech Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Security Officer Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Christine Cupo Charles Caggiano other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> .. Page 1 and 2 sh tment of Health a tant: If item 27 is 2303 Sparrows Point Road Sparrows Point, MD 21219 Donna Madigan /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bate 02 permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2009 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1401443 Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician nemic disease or condition resulting in death) VI ZWI Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immedicause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a as the burial-Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Division of Vital Records, P.O. Box Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed completed filled in by the funeral director, page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Dear 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 Tose 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar ARRON

31 Date filed (Month, Day

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 September 11:00 AM Sally Cornell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac 11133 Hurdle Hill Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, October 3, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number Ohio **Funeral** 1 □ M 2 🛣 F 82 281-24-9113 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c City Town or Location 10a. State 10b. County 28a-f show 1 Tyes 2 No Director event, the Medical Everning remark by notified Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 20854 United States items 23a 11133 Hurdle Hill Drive r death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White "natural", or 1 ☐Yes 2X No Specify. Specify: þ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than any Injury or other traumatin. Elementary/Secondary (0-12) College (1-4or 5+) Antique Dealer Antiques 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ge Be Edith Florence Trask Francis Marion Osborne, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11133 Hurdle Hill Drive, Potomac, Maryland 20854 Owen M. Cornell, III/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) October 2, 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral dervice Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death 12 Months Immediate Cause (Final disease or condition resulting in death) Lung Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 ☒No 5 Other (specify) ned by the detached f 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 💆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 🕅 No certificate 1 ☐Yes 2 ☐ No Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. spital or Attendi nours after death. neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie September 29, 2009 D0062234

State Registrar 31. Date filed (Month, Day, Year)
OCT 02 2009
Server S. Signature

9. Aparts

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manish Agrawal, M.D. 9707 Medical Center Drive, Suite 300, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 31567

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 30, 2009 **Physician** Hendrikus Daniel DeVroom 12:10 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3504 Twin Branches Court Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min 1 X M 2 □ F 88 Vre 578-04-9043 April 10, 1921 The Netherlands Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed at once. 28a-f show 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3504 Twin Branches Court 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Year or Dates Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) International Monetary Elementary/Secondary (0-12) College (1-4or 5+) Consultant Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johannes Hendrikus de Vroom Cornelia Pieternella Elve ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hetty L. DeVroom/ Daughter 12611 Granite Ridege Drive, N. Potomac, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State October 2, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland Fumphrey Funeral Home/ Montgomery Avenue 2009 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 21. Signature of Funeral Service Licensee To M01498 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Deep Vein Thrombosis /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if a ly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine The law requires that the death certificate be executed tran and Due to (or as a consequence of) physician a s the burial-Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 Unknown 9 Unknown signed by t σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has S autopsy page (1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this (٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

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filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal completely her: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the sadas(s) and manner than the sad 2 Medical Exam (Check only one) To the I within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) September 30, 2009 D40948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julie K. Fox, 2101 Medical Park Drive, #301, Silver Spring, Maryland 20902 31. Date filed (Month, Day, Year) .32. Registrar's Signature Registrar

		4	. For	aryland / Depa			lental Hyg	iene	10 01500				
	1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De												
Physician/				ando	Enekw	e	Month 09	Day Y	/ear 4:00a M				
Medical Examiner			4a. Facility Name (if not institution, give street and number) 2206 Lawnwood Circle	4b. City, Town, or L Balti	ocation of Death		4c. County of Death						
Ī	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age	e (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04	Year)	9. Birthplace (State or Foreign Country) Nigeria				
	d t	. I	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation	*			10d. Inside City Limits				
	larylar Ba-fsf ified	Funeral Directo	MD NA	Balti					1X Yes 2 □ No				
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 2206 Lawnwood Circle	10f. Zip Code 21 2	207		Citizen of What Country? U • S • A •						
920			11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No.	Was Decedent of His f Yes, specify Cuban, I ☐ Yes 2x No	, Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indian, White, etc. Black				
21215-0036		Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give I	dent's Usual Occupat kind of work done du O NOT use retired)		ng [iness Industry Cerebral				
12	dygien Hygien Ither ti	Be C	12th grade 6yrs 17. Father's Name (First, Middle, Last)	Ма	nager	18. Mother's Name		Paisy Maiden Surname)					
land	l be file fental l rked c ric eve	일	Alfred Enekwe			Cather							
Maryland	12 should atth and M 27 is mai r traumat		19a. Informant's Name/Relationship (Type, Print) Patrick Enekwe-Brother	19b. Mailir 220 6	ng Address (Street an	nd Number or Rura	Route Number,	City or Town, Sta Ltimore	te, Zip Code) , Md 21207				
Baltimore,	e 1 and t of He If item or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)		20c. Location - C	City or Town, State				
ţim	it. Pag intment intant: njury o		4 ☐ Donation 5 ☐ Other (Specify)		matory or other place, Family		7/09	Ajall	i, Nigeri <u>a</u>				
Ba	permit Depar Impor any in		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
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Box 687	ath certific attending p for use as	Completed by Physician/Me	FFEMALE: 23c. If yes, outcome 23c. If yes, outcome 1	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		23d. Date Mont	of delivery th Day Year				
s, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death b	oute to the cause of death?									
Division of Vital Records,	e law requ s has been ge 2 shoul						24a. Was a autop perfor	sy pr med2 de	ere autopsy findings available ior to completion of cause of eath?				
al R	an: Th tificate tor, pa	Be Co	25. Was case referred to medical		26. Pla	ce of Death (Check	1 Yes	2 No. 1	Yes 2 No				
∠it	hysici his cer il direc	유		ient 2 ER/Outpatie		4 □ Nursing Ho		ence 6 Other					
n of	ding P h. After t funera	Medical Certificate:	27. Manner of Death 1 Natural 5 Pending (Month, Da 2 Accident Investigation	ury 28b. Time o injury injury	work?		28d. Describe ho	ow injury occurred	1				
ivisio	I or Atten after deat Director; I in by the		2 Could not be	ury - At home, farm, str c. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
2	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to an extension of the funeral director, page 2 to a completed filled in by the funeral director.		29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
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	カン		30. Name and address of person who completed cause of a		Print)	Parl Pla	ce .	Bultimo	16 31303				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registr	rang Signature									

within 24 hou To the Fune completely fi

State Registrar

Day, Year) 02

BLOOMING DALK AUE FEBRALS BYZGMD INBOLD, MD 32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ye ar **Physician** $a^{\ M}$ 09 30 2009 11:30 Fowler W. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 2327 Ellen Street Baltimore 8. Date of Birth (Month, Day, Yea 12/02/1936 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs. Maryland Director 217-34-6425 72 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 U.S.A. 2327 Ellen Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 X Never Married 2 ☐ Married 1 XYes 2 □ No Maryland 21215-0036 If Yes, Give Year or Dates: 1962. 1 ☐ Yes 2 X No Specify à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer MD Specialty Wire 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental is marked c Mildred Α. Fowler မ Lee traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health of Item 27 is <u>3205 Rosalie Avenue, Baltimore, MD 21234</u> Linda Brown, Cousin altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/03/2009 4 Donation 5 Other (Specify) Glen Burnie, Maryland Glen Haven 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. alxandra 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Betwood Onset and D 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence oi) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached fi 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ∏Yes 2 ∏ No s certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ■ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manger stated 29b. Signa ted cause of death (Item 23a) (Type Prin

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 3:07 Septem 2004 hurman Faison /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs.
Months Days Horror Baltin N/A Bon SELOUIS Hospita Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1⊠M 2□ F 66 Yrs. NORTH CAROLINA Director FEB 7 243-64-9447 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, "In Mutcal Expr. in a Traum to prove the standard of the content of the standard of the sta 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 □ No Directo BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1935 W MULBERRY ST. 21223 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: BLACK ģ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD INDUSTRY COOK 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ODELL HOBBS LEO FAISON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1935 W. Mullberry St., Baltimore, Md., 21223 Rita Diane Faison/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 🖾 urial 2 □ Cremation 3 □ Removal from State 10-10-09 LANSDOWNE, MARYLAND MT. ZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Lice Lee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. aller 1206 W NORTH AVENUE 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 5 hock /Medical resulting in death) Due to (or all a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dreumonia Examiner respira and as the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician The law requires that the death certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð þe 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 □Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division of Vital Records, 24 hours after death.

Funeral Director: A completely within 2.

> State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000 W

32. Registrar's Signat

29c. License number

Baltimore

66108

51.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 2:15 p^M September 29, 2009 Robert Joseph Fleming 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford Four Seasons Assisted Living Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 1**∑** M 2□ F Months Days Hours Min July 10, 1923 Kansas 490-44-8543 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Maryland Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 1861 Trudeau Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1—Tyes 2 ☐ No If Yes, Give Year or Dates: 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. 3₺ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tug Boat Operator <u>Civil Service</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Christdana McGrath Joseph James Fleming 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1861 Trudeau Drive, Forest Hill, MD 21050 of Disposition (Name of Date 20c. Location - City or Town, State Christy L. DeMarco / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gdn 9-2-09 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Huneral Service Licenses Hhulen A 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): IONIC that initiated events resulting in death) Last Due to (or as a consequence of): 20STATIC IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1X(No 1 □Yes 2 No 25. Was case referred to medical

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

examiner?

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

1 Yes 2 No

5 Pending

investigation 6 ☐ Could not be determined

OCT 02

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, it a Moxical Engineer must be notified at once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar s been signed by the should be detached certificate has b irector, page 2 st

requires that the death certificate be executed 68760 Box P.O. Records, Vital director, this o After the o the Hospital or Attending Phithin 24 hours after death.
o the Funeral Director: After the ompletely filled in by the funeral Division

H895

2

26. Place of Death (Check only one)

Other: AN Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

1 □Yes 2 □ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and the of certifier MI 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BEIAIR MD2/0/4 60 GATBWAY DRIVE, ANUSUA QUITE 2 - SIRITHARA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, 5

		For State Registrar			Marylan		artment of rtificate of			g. No.	0119	3 5 7
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Examin	G!	4a. Facility Name (If not 2009 Wood)	berry	Street			Hyatts			1	nty of Death	-
uneral irector		5. Social Security Numb 578-50-9362 Usual Residence of Dec	2	Sex 7 1 ☑ M 2 ☐ F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days			_{Year)} L940		place (State or Forei ntry) ngton, DC
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23a or 28a at be noti	Funeral Director	10e. Street and Number		treet			10f. Zip Code 2078	32	10	0g. Citizen US	of What Cou	ntry?
5,5	þ	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Deced Armed Forc 1 □ Yes 2 If Yes, Give Year or Dat	es? ☑ No		Was Decedent of f Yes, specify Cui	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	1	Race - Ameri Black, White, ecify: B	
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ant: If Item ury or oth		20a. Method of Disposit 1 X Burial 2 ☐ Cr 4 ☐ Donation 5 ☐	remation 3			mony Ma	sition (Name of natory or other pla morial Pa	rk 10/0	06/2009 1	Landor		aryland
Importa any Inju		21. Signature of Funda	Service Lic	ensee					hnson & J , NW, Was			
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sicia	al Ex	Sequentially list condition of any leading to immed cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	iiate g y	с	r as a consequ							
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sate has been si page 2 should I	Completed								24a. Was ar autops perform 1 □ Yes 2	V	prior to c death?	opsy findings availal ompletion of cause o
ector	Be	25. Was case referred t examiner? 1 ☐ Yes 2 No	o medical	Hospital:	patient 2 🗆	ED/Outpotion	nt 3 DOA	26. Place of De	eath <i>(Check only on</i>		Other (Cose	74. A
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ne Fune pletely fi	Medical	29a. Certifier 1 2 one)	Certifying F Medical Ex	Physician: To the bas aminer: On the bas and manne	sis of examina	wledge, deat ation and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occ	ce, and due to the courred at the time, d	ause(s) an ate and pla	d manner as ice, and due	stated. to the cause(s)
To th	Me	30. Name and address 31. Date filed (Month, D	of certifier	· M			29c. Licer	nse number	2	9d. Date si	gned (Month	Day, Year)
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6				ne (First, Middle, La	st)						2. Date of De	eath Da	v Year	3. Time of Death
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0	land		Usual Residence o 10a. State	10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
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200	h the)irec	10e. Street and Nu	ımber				10f. Zip C					tizen of What Co	untry?
121	death with the Maryland ms 23a or 28a-f show	ral	304 N.	Kent Str	eet			216					U.S.A.	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Medical Evanters in unit by motified at	d by Funeral Director	3 X Widowed		12. Was Deceder Armed Force: 1 ☐ Yes 2 ₹ If Yes, Give Year or Date:	s? ∑]No		1∐Yes 2∑	∑ No	dispanic Origin? (Span, Mexican, Puerto Specify:	to Rican, etc.) Black Specify:			hite
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la la	Aenta Aenta rked tic ev	To B	Wiebe				Gi	$c \infty t$		Aggie				Mars
Maryland	nd 2 shou alth and M 27 Is ma r trauma			lame/Relationship	(Type. Print)					and Number or Ru treet Wy				Zip Code)
JOh Baltimore,	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important: If item 27 Is marked other any Injury or other traumatic event, III once.			•	Removal from Sta	te i	tany Gi	osition (Name matory or oth fts Regi	istr	y 9/30	Date 0/2009	Hat		Maryland
, Balt	permit. Depart Import any Inj once.		21. Signature of	uneral Service Lice	nse					ss of Facility Ar				
9	Physician /Medical Examiner	Examiner	23a. Part 1. Enter shock, or her shock, or h	art failure. List only (Final on	b	sed the death h line. as a consequal	uence of):	ter the mode			or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,5	rate be executhysician and the burial-tra	edical Exar	that initiated event resulting in death)	Last	Due to (or :	as a consequ	uence of):							
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	2 months?	23c. If yes, outcor 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 ☐ Feta ntat time of d	I death 3	□ Ectopic pre		cy			23d. Date of de Month	livery Day Year
ds, P	uires that signed b d be deta		Part II. Other signi		contributing to death			underlying cau	ıse giv	ven in Part I.			use contribute to	o the cause of death?
Division of Vital Records, P.O.	The law req ate has beer bage 2 shou	Completed by		V	1.						per	s an opsy formed? 2 N	death?	utopsy findings available completion of cause of
ita	sian: ertifica ctor, p	Be C	25. Was case refe examiner?	rred to medical						26. Place of Dea				
of V	hysic this ce Il dire		1 ☐ Yes 2-1	No				ent 3 DOA		4 LI Nursing F			6 ☐ Other (Spe	ecify)
ion o	nding Path. r: After t e funera	ation:	27. Manner of Dea 1. Natural 2 Accident	ath 5 □ Pending investigatio		njury <i>Day, Y</i> ea <i>r)</i>	28b. Time Injury	of 28	c. Injur Worl	ryat rk?]Yes 2 □No	28d. Describe	e how inju	iry occurred	
Divis	il or Atte after deg Director d in by th	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined		Injury - At ho etc. <i>(Sp</i> ec <i>if</i>	ome, farm, s	reet, factory,	office			(Street a own, Stat		ural Route Number,
	e Hospite 24 hours e Funeral letely fille	Medical C	29a. Certifier (Check only one)		hysician: To the be miner: On the basi and manner	s of examina								
	To the To	Me	29b. Signature and	d title of certifier				29c.	Licens	se number		29d. D	ate signed (Mon	th, Day, Year)
			1	Bel				D	00	50996		91	128/00	,
	\		Neil St	toddavd	completed cause of	Brow	onSt.	Chest	ovt	Town Mi	0 216	20		
	Sta Registi		31. Date find (40)	7 2 2009	Service 32. Regi	istrar's signa	gar.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Las. September Year 10.02 PM **Physician** 29 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore Hares If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, 5. Social Security Number (In yrs. last birthday, **Funeral** 1 □ M 2 🕏 F 229-62-083 Director Usual Residence of Deceden filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Exeminar must be notified at Yes 2 No Director Himore 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American India 11. Marital Status 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes Specify \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Name (First, Midele, Maiden Surname) 17. Fathers Name (First, Middle, Be Pages 1 and 2 should be ပ 19b. Mailing Address (Stre , and Nymber or Rural Royle Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 isany injury or other trau doug Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ignat art 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he rt, ailure. List only one cause on each line. Approximate Interval Between Onset and Death Imr ediate Cause Final direase or con Hon sulting in death) Hroara **Physician** 3 Days Cerebra /Medical Due to (or as a consequence of) **Examiner** Prewmonia Aspiration Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner years Disease Coronary burial-tran P.O. Box 68760 5 Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No the detached 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Wital Records, 1 Tyes 2 No 3 Probably 4 TOnknown funeral director, page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐Yes 2 ☑No certificate 1 ☐ Yes a No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 24 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier WD 24069 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Baltimore Wo TIN T Avenue Caton

DHMH 17 Rev 1/2001

Registrar

HLAING

31. Date filed (Month, Day, Year)

0 2 2009

900

32. Registrar's gnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Of Mary Registrar		rtificate of l			eg. No.	0 3 5 7		
	Physicia	212	1. Decedent's Name (First, Middle, Last)				Date of Deat Month	th Day Year	3. Time of Death		
	/Medic			fmaster_			Septemb				
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of De	erick		
- Parad			9742 Steiner Smith Road 5. Social Security Number 6. Sex 7. Age (II	'n yrs. last birthday)	If Under 1 Year	dsboro If Under 24 Hrs.	8. Date of Birth		SETCK irthplace (State or Foreign		
	Funeral Director		219-14-9543 Usual Residence of Decedent	88 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 2,	1920 I	Maryland		
	land ow			oc. City, Town or Loc	cation				10d. Inside City Limits		
	Mary Ff sh	ţ	Maryland Frederick		Wo	odsboro		1 ☐ Yes 2X No			
	h the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?				
	th wit	al D	9742 Steiner Smith Road		21	798					
9	72 hours after death with the Maryland "natural", or items 23a or 28a-f show	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Veys 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, F			ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, ite, etc.		
21215-0036	2 hours	ted by	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	ation	ina	16b. Kind of Busines	hite s/industry				
21	within 72 ho iene. than "natur re ivedical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			during most of work i)	mg	a_ 2.			
2	2 2		17. Father's Name (First, Middle, Last)		arm wife	18. Mother's Name	e (First Middle, I	dai: Maiden Surname)	су		
Maryland	be od o	Be	Jessie Wiles			10. Moulet 3 Name	Bertha				
7	2 should be 1 and Mental Is marked o aumatic eve	မ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	a Address (Street	and Number or Run		r, City or Town, State	. Zip Code)		
	s 1 and 2 should f Health and Mei tem 27 is marke other traumatic		Earlene F. Main/ daughter	I	-	stown Rd.		rmont, MD			
ē,	s 1 and 2 of Health Item 27 I		20a. Method of Disposition	20b. Place of Dispo- cemetery, cren				20c. Location - City			
Ę	Pages nent of ant: If Ite arry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Hope		1	/2009	Woodsbore	o, MD		
Baltimore,	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Licenses	/ 22		ss of Facility Hai	rtzler F	uneral Ho	ne		
			23a. Part 1. Enter the disease, or complications that daused the shock, or heart failure. List only one cause on each line.					•	Approximate		
	Physician		Immediate Cause /Final						Interval Between Onset and Death		
	/Medical		disease or condition resulting in death) a. atherosc. Due to (or es a co	lerotic consequence of):	ardiovasc	cular dise	ease		years		
	Examiner		Sequentially list conditions b.								
	pe tis	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	onsequence of:							
200	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a compared to the com	onsequence of):							
68760,7	tificate be execufed g physician and as the burial-transit	alE		,							
687	rtificate ng phys as the	ledical	d	-	019						
		N/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2		Testonio prognana			23d. Date of			
B	deat he att	Physician/M	1 Yes 2 No 4 Pregnant at tin		☐Ectopic pregnand ☐Other (specify) _	-y		Month	Day Year		
P.0	that the de ned by the a detached t	Phy	9 Unknown		4-14	'. D.A.I	220 Did to	hanno uno contributo	to the cause of death?		
ds,	The law requires that the death cer are has been signed by the attendir page 2 should be detached for use		Part II. Other significant conditions contributing to death but n Diabetes hypertension	not resulting in the ur	nderlying cause giv	en in Part I.			Probably 4 Unknown		
of Vital Records,	w requires to be a should be a	Completed by	Diabetes Hypertension				24a, Was a	an 24h Were	autopsy findings available		
Rec	The law cate has page 2 s	μ			· · · · · · · · · · · · · · · · · · ·		autop: perfor	sy prior i med? death	o completion of cause of		
ā			25. Was case referred to medical			26. Place of Deat			es 2□No		
5		o Be	examiner?	2 ER/Outpatier	nt 3 DOA Oth	Of:		lence 6 Other (S	pecify)		
0	g Physer this seral di	n: To	27. Manner of Death 28a. Date of Injury			ry at		ow injury occurred			
io	Attending r death. ector: After by the fune	atio	2 Accident investigation	car, injury		Yes 2 □No					
Division	i Pite	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,		
	Hospital 24 hours 2 Funeral I etely filled	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of read and manner stated	xamination and/or in							
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)		
	->-0		Muchke in		DO	031058		9/21/	2009		
	4		30. Name and a ress of person who completed cause of deat	th (Item 23a) (Type,				2,2,7			
	8		Cene Ashe	10200 Cc	ppermine	Rd. Wo	odsboro.	MD 21798			
	Sta Registr		31. Date filed (Month, Day, Year) 82. Registrar's	Signature	e)						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b PerFH G896:10/1/09 WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JACKSON 5:45 PM **Physician** 2009 27 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 3108 TIOGA PARKWAY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex last birthday) Funeral Days OYrs. North 1 M 2 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, II a Martical Experience country to it of life 4 at H'more 1 Yes 2 No Director 10g. Citizen of What County? Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 KNNO If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No 3altimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life PO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event and once. College (1-4or 5+) Elementary/Secondary (0-12) Teache 18. Mother's Name (First, Middle, Maiden Surname) Name (First Middle Be 19b. Mailing Address (Street and Number 3/08 7. cqA or Rural Route Number, City or Town, State, Zip Code) SON ACKSON enor Place of Disposition (Name of cemetery, cromatory or other p 20a. Method of Disposition Burial 2 Cremation 3 R 3 Removal from State ides 22. Name and Address of Facility 21. Signature o Funeral Service Licensee 23a Pax 1. Enter the Isease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he are failure. List only one cause on each line.

Introducted Cause (Final Sease) or condition resulting in death)

a.

Due to (Sease or condition) Approximaté Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Chronic Kidney diseas if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) Examiner NEPHROSCLEROSI or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial-transis HYPERTENSIVE Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): HYPERTENSION Physician/Medical DECADES IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 25 No 3 Probably 4 Unknown ARTERY DISPLASE 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 📉 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ∐Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00064609 SEPTEMBER 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) 3100 WYMAN PARK DRIVE BALTMORE MD 21211 REEDWAN MD 32. Registrar's Sgnature State Registrar

DHMH 17 Rev 1/2001

	1 - For State Registrar	State of Maryland	Certifica				Reg. No.				
hysician /Medical	1. Decedent's Name (First, Middle, Le WILHELM JOECKEL	ast)				2. Date of De Septem	ber ^{Day} 30,				
Examiner	4a. Facility Name (If not institution, gi Manor Care Ruxton	1	To	y, Town, or Li				Itimore			
Funeral Director		Sex 7. Age (In yrs. la. 75	Yrs. Month		If Under 24 Hours N	Alin. June 14	7934	9. Birthplace (State or For			
a-f show	10a. State 10b. County		Town or Location				10d. Inside City Limi 1 □ Yes X XIN				
r Items 23a or 28a-f sl Instrumst by natified Funeral Director	10e. Street and Number 8 Pebble Lane		10f. 2	21093	3		10g. Citizen of US/	•			
Examiner multiple statements of the Funer statements of the statement of the statements of the statement of the statements of the statemen	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes X X No If Yes, Give Year or Dates:	. 13. Was Dec If Yes, sp 1 □ Yes		panic Origin , Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Rad Bla Specif	ce - American Indian, ck, White, etc. iy: White			
ygiene. ner than "natura t, the Medical E Completed	15. Decedent's E(Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16a, Decedent's Us (Give kind of v life, DO NOT Hair St	vork done du use retired)	ion ring most of	working		ousiness/Industry Owner			
arked other atic event, to	17. Father's Name (First, Middle, Las	rt)	11027	-		Name (First, Middle ne Fey					
27 is marr trauma	19a. Informant's Name/Relationship Erika M Joeckel	(Type. Print) Wife	19b. Mailing Addre	ss (Street an Lane	nd Number o Timoni	um Maryla	nd 21093	, State, Zip Code)			
Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it at Medical Examinate mantal examination once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 Divermation 3 4 Donation 5 Other (Special Section 2) 21 Ignature of Funeral Stryide Lice	Gree	ace of Disposition (Nametery, crematory of Phone Cr	emator and Address	ry Oct	chell-Wie	Baltimo defeld I	-CityorTown, State Ore, Maryland Funeral Home Maryland 2121			
physician and street burial-transit and unital-transit and unital-tran		mplications that caused the death. y one cause on each line. a. Due to (or as a consequence) Due to (or as a consequence) C. Due to (or as a consequence) Due to (or as a consequence)	ence of:	ode of dying,	, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Betwee Onset and Deat			
ed by the attending parters of the steached for use as Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopi	c pregnancy (specify)				ate of delivery Ionth Day Year			
en signed be uld be deta	The state of the s	contributing to death but not resul	Iting in the underlyin	g cause giver	n in Part I.		tobacco use cor Yes 2 ☐ No	ntribute to the cause of death			
cate has been s page 2 should						24a. Was auto perfi 1 🗆 Yes		Were autopsy findings avait prior to completion of causideath? 1 □Yes 2 □Mo			
this certificate al director, pag		Hospital: 1 ☐ Inpatient 2 ☐ B	ER/Outpatient 3 🗆	Othor		Death (Check only ing Home 5 Res		ther (Specify)			
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	27. Man of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide	on be 290 Place of Injury . At hou	28b. Time of Injury M me, farm, street, fac	-	at es 2 □No	28f. Location	how injury occu (Street and Num wn, State)	rred nber or Rural Route Number			
ithin 24 hours the Funera ompletely fills Medical (29a. Certifier 1 CertifyIng (Check only 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examinat and manner stated.	tion and/or investigat	ion, in my op	inion, death	place, and due to the occurred at the time	, date and place	, and due to the cause(s)			
To con	29b. Signature and title of certifier			29c. License	14 A 7	17	100	ed (Month, Day, Year)			
	N/Y	completed cause of death (Item			, , ,	ouds Pre					

DHMH 17 Rev 1/2001

State Registrar

09-07264
Gabriel Johnson

Dabriel Johnson		Amend Item 8 per sa Servicial of Death 1- For State Registrar	ygiene Red	. No.	9 3158
Physicia	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month September		3. Time of Death 1456 hrs
Medical Exami	ner	Gabriel Johnson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		16, 2009 4c. County of Death	
		47 Shipping Place Apt. A14 Dundalk		Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or unk
Director		212-30-6144 1X M 2 F 76 Yrs. Months Days Hours Min.	Aug 29	. 2009 Co	untry)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		He	10d. Inside City Limits
≱ .∗	٠	MD Baltimore Dundalk			1 Yes 2 No
arylan 8a-f sl	Director	10e. Street and Number 10f. Zip Code	100	. Citizen of What Cou	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once,		47 Shipping Place #A14 21222		USA	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. of other than "natural", or items 23a or 28a-f she, the Medical Examiner must he notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 4. Married Porces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?)		14. Race - Amer White, etc.	ican Indian, Black,
er dear		1 Yes 2 No specify:		Specify: wh:	ita
urs aft itural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v			
6 172 hc cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use reti	red)		
003 withir giene.	dmo	unk unk Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name	/First Middle M	oldon Curnomo)	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	Be C	17. Father's Name (First, Middle, Last) unk 18. Mother's Name	(First, Middle, Mi	alderi Sumame)	unk
2121 hould be find Mental is marked utic event,	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Fdward Johnson-brother 3009 Texas Ave Ball	Rural Boute MD	e 29it234 own, State	e, Zip Code)
2.5 S T 2.7 Z		111 Penn Street Balti	lmore, MI) 21201	
nore, Nages I and nt of Healtl it: If item other trau		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
트리트 등 로	ļ	4 Donation 5 X Other Specify: in State 21. Signature of Funer, Service Licensee 22. Name and Address of Facility			
Balt permit Depart Impor injury	ļ	Renald S. Wade Arector State Anatomy Board			Street
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of)] r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical ¬xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Head injury			Death
. Xammor		or condition resulting in death) Due to (or as a consequence of):			
	힐	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			_
_	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated experts resulting in death). Last			
uted nd ransit		d.			
760, icate be executed physician and the burial - transit	Medical	X UNPENDED AMENDED 23a,27,28a-f, per ME, G896 10	/22/09 T	T	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live high	= = = = = = = = = = = = = = = = = = = =	23d. Date of deliver	
Box 687 death certific the attending p	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ancy	Month	Day Year
Bo be deat the at	hys	1 Yes 2 No 9 Unknown 9 Unknown			
i, P.O. B ires that the d signed by the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death? bably 4 V Unknown
dS, F	ted		24a. Was a		utopsy findings available
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tal Rec		25. Was case referred to medical 26.Place of Death (Check	1 ✓ Yes 2	No 1 ✓ Y	es 2 No
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n of \ding Phy.	-	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	_	w injury occurred	
ivision or Attendi after death. Director:	atio	Natural 5 Pending Pend	unk		
Divis N or A safter I Dire	Certification:	3 Suicide 6 X Could not be determined (Specify) residence	28f. Location (St or Town, Sta	reet and Number or Ri ate 47 Shipp	ural Route Number, City
lospitz t hours unera		29a. Certifier a Continued Physicians. To the heat of my knowledge, death ecoursed at the time date and place and	Dundalk,		ted last
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date a	nd place, and due to the	ne cause(s)
₽ ≥ ₽ 8	₽	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
		Caral Hallan O.C.M.E.		September 17, 2	2009
		30. Name and address of person who completed cause of death (Item 23a)	11		
	ate	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120 31 Date filed (Month, Day, Year) 32 Registrar's Signature			
Regist		OCT 0 2 2009 Rever A. Sark			
DHMH 17 Rev 1/20	10.1	ORIGINAL			

			For State Registrar	State of M	/larylan		artment of F rtificate of		and Me	-	giene Reg. No.	2009	3 58
			1. Decedent's Name (First, Middle, L	ast)					2	. Date of De			3. Time of Death
	Physici		Willie Edna j	ackson					5	Month SEOT.	25 Day	- 2009	0858M
10 mg	/Medio Examir		4a. Facility Name (If not institution, g		r)		4b. City, Town, o	or Location o		7	4c.	County of Deat	
ومي			Penissula levil	nal med	ical	Contra	50	lich	1/11			Wicher	rico
	Funeral		5. Social Security Number 6.		Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under	24 H/s. 8 Min.	. Date of Bir (Month, Da	th v Year	9. Birt	thplace (State or Foreign ountry)
	Director		220-03-6021	1□M 2∏F	89	Yrs.	World's Days	Hours		lay 5.	1920	_	ryland
	pu ,		Usual Residence of Decedent		140. 01					•			10d. Inside City Limits
	aryla shov	'n	10a. State 10b. County MD Wicom		Too. City	y, Town or Lo							1 ☐ Yes 2√ No
	Ba-f	ecto		100		Salis					10 000		
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28e-f show ont, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 105 Times Squat	re			10f. Zip Code	21801			rug. Citi	zen of What Co USA	ountry :
	sath is 23	era		12. Was Deceder	at Ever in 11:	S 112 1			iain? (Snaci	ty Voe or No		14. Race - Ame	prican Indian
	item item	F	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	5?	3.	Was Decedent of I If Yes, specify Cub	an, Mexican	n, Puerto Ri	can, etc.)		Black, White	
38	Is af		3 Widowed 4 Divorced	If Yes, Give			1∐Yes 2∭INo	Specify:				Specify:	white
ŏ	atura	bed	15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation		unk	16b. Kir	nd of Business	Industry unit
215	in 72	ple	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4o	r.5.\\	(Give life.	kind of work done DO NOT use retire	during mos d)	t of working				
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	e file al Hy othe vent,	Be C	17. Father's Name (First, Middle, Las	st)					,	First, Middle		Surname)	
<u>la</u> ı	uld by Menta rrked ric e	2	John J. Dennis					H.	attie	Y. Tw	igg		
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number	er or Rural I	Route Numb	er, City o	r Town, State,	
	1 and 2 Health a tem 27 is		Penninsula Gene	rai Hospi	tal	100	E. Carro	oll St	reet S	salisb	ury,	MD 21	.801
ore	of He	-	20a. Method of Disposition	FTD 16 00	20b. P	lace of Dispo	sition (Name of natory or other pla	ce)	Dat	e	20c. Lo	cation - City or	Town, State
Ĕ	Pag nent ant: I		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spec		ie	•		1					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Macical Examiner must bu notitied at once.		21. Signature of Funeral Service Lic Ronald S	ensee	rector	22	2. Name and Addre	ess of Facilit	ty Card	655 W	Ral	timore	Street
<u> </u>	89 E 29		Sum /	1000th	rector	Ba	tate Anat altimore,	MD	21201	000 W.	. Dar	CIMOIC	
			23a. Par 1. Enter the disease, or co show, or heart failure. List on	mplications that caus	ed the death	n. Do not ent	ter the mode of dy	ing, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition			nti c	ardiovase	112	dicas	10			Onset and Death
	/Medical		resulting in death)	- и	as a consequ		20.04.04(12	ara-	CV-1 CD-	,,, ,		-	
	Examiner			Hyp	extensi	m							
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	a cursequ								
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o,	cate be executed physician and the burial-transit	Ä	resulting in death) Last	Due to (or a	as a consequ	uence of):							
8760,	ate b nysici	dical		d									
	ng pl	Med	IF FEMALE:										
Вох	The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			☐ Ectopic pregnan	cv				23d. Date of de	*
Э. Е	ed fo	sici	in the past 12 months? 1 □ Yes 2 XNo	4 ☐ Pregnan 9 ☐ Unknow	t at time of d		Other (specify)					Month	Day Year
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Vital	siclan: The certificate h rector, page	Be C	25. Was case referred to medical					26. Place	e of Death (Check only			
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lof	ding Pt n. After th funeral	Ę	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of I	njury Day, Year)	28b. Time o Injury	if 28c. Inju	ury at	28	d. Describe	how injur	y occurred	
<u>ō</u>	ath.	atic	2 Accident investigat	on				Yes 2□	INo				
Division	er de recto	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of	Injury - At ho	ome, farm, st	reet, factory, office		28	If. Location ((Street an	nd Number or F	Tural Route Number,
Ö	tal or rs aft all or all Direction	Certification: To			, ,					,	,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examina	wledge, deat ation and/or in	th occurred at the avestigation, in my	time, date a opinion, dea	nd place, ar ath occurre	nd due to the d at the time	e cause(s , date and	i) and manner a d place, and du	as stated. e to the cause(s)
	o the vithin o the complex	Mec	29b. Signature and title of certifier		J.M.O.G.	_	29c. Licen	se number			29d. Da	te signed (Mon	th, Day, Year)
	⊢≶⊬ŏ		3	mos And	1		ħ	68777	_			09-71	5-09
			30. Name and address of person wh	o completed cause of	of death (Item	n 23a) (Tvne	Print) ST. S	3				- ,)	,
			RAZA AFZAL W	D Inns	CAL	noll	57 5	Alic	hun	· m	d	2180	/
	C+-	ate	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	iture .	21. 0	11113	Durch	7			<u> </u>

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** EILEEN BODKIN KELLY 2009 October 0 1, 3:15P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County

Bidblace (State or Foreign STELLA MARIS Timonium If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 27, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1915 1 □ M 2 🔀 F 93 Maryland 220-09-2262 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the World Event and the notified at 1 ☐ Yes 2 No Director Maryland Baltimore County Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2300 Dulaney Valley Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Interior Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Patrick Kelly Birmingham OCTOBER 1, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James W. Stevens (P.R.) 8 Overidge Court, Baltimore, Maryland 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount CrematoryOct 3, 2009 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signal red or Fundal Se vice Liberts purson MIICHELL-WIEDEFELD FUNERAL HOME, INC Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician**)ays meumona /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 2XNo P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy , page certificate 1 ☐ Yes 2 🗵 No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1∏Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attending Injury To the Hospitai o. within 24 hours after death. To the Funeral Director: Af 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year)

Registrar

State

2300 DULANEY VALLEY ROAD

TIMONIUM

21093

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2.500 Di 32. Registrar's Signature

ERNESTINE WRIGHT, M.D.

31. Date filed (Month, Day, Year)

Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

			or Print in Blac			_	_	
	-	1 _ State	ate of Maryland / [Department of He Certificate of D			jiene leg. No. Para C	01200
_		Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
Physicia /Medic			nnedy			Month	26 200	7 1810 1
Examin	er	4a. Facility Name (If not institution, give street	, inec	4b. City, Town, or L	ocation of Death		4c. County of Dea	ath
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y Year) 9. Bi	rthplace (State or Foreign country)
Director		161-48-7043 Usual Residence of Decedent	52	Yrs.		Jan. 16	, 1957 Pe	nnsylvania
ryland	_	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the Ma	Director	Maryland Harford 10e. Street and Number	Abingd	On 10f. Zip Code			10g. Citizen of What C	
3a or		604 Falkirk Court		21009			USA	
r deat tems 2	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S. rmed Forces? Yes 2 No	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spe , Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
ified within 72 hours after death with the Maryland Hygiene. Hygiene. The Hygiene than "natural" or items 23a or 28a-f show ent, the Modical Examinet must be notified at	þ	If	∐Yes 2∐4No Yes, Give ear or Dates:	1 □Yes 2 XNo	Specify:		Specify: W	hite
72 hou	Completed	15. Decedent's Education (Specify only highest grade com		. Decedent's Usual Occupa (Give kind of work done du	uring most of workir	ng	16b. Kind of Busines.	s/industry
within iene. than	dmo	Elementary/Secondary (0-12) C	ollege (1-4or 5+)	'life. DO NOT use retired) roduction Pla			Aerospace	Defense
e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Surname)	
2 should be and Mental is marked or raumatic even	Lo	Bernard John Kennedy		o. Mailing Address (Street a	Mary Gra			Zin Code)
and 2 steath an m 27 is rher traur		19a. Informant's Name/Relationship (Type. P Karen Anne Kennedy		04 Falkirk Ct				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tier Z7 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Marylan Examinet must be notified at once.		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Remove	20b. Place of cemeter	of Disposition (Name of ery, crematory or other place) D	ate	20c. Location - City of	or Town, State
iit. Pag urtmeni rtant: njury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Hillt	op Service Co	- 1		Towson, Ma	aryland
permi Depar Impor any Ir		telle A alex	di	McComas Fur 1317 Cokesh				and 21009
		23a. Part 1. Enter the disease, or complicator shock, or heart failure. List only one car	ns that caused the death. Do use on each line.	not enter the mode of dying	g, such as cardiac c	r respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician // // // // // // // // // // // // //		Immediate Cause (Final disease or condition resulting in death)	Subara	chnoid	hemor	rhag	e	
Examiner		h	Due to (or as a consequence	on:		V		
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):				
e be executed sician and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence	of):				
eath certificate be exattending physician for use as the buria		L d						
certific	Physician/Medical		yes, outcome of pregnancy				23d. Date of c	delivery
death he atter	siciar	in the past 12 months? 1 □ Yes 2 □ No	Live birth 2 Fetal deat Pregnant at time of death Unknown	h 3 Ectopic pregnancy 5 Other (specify)	·		Month	Day Year
ires that the de signed by the a		9 ☐ Unknown Part II. Other significant conditions contribu		in the underlying cause give	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?
equires 1	d by	myocardial	infarction	7		1 🗆 🗅	Yes 2 □ No 3 □	Probably 4 Unknown
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ing Ph	on: T	1 ☑ Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day, Year) 28b.	Time of Injury 28c. Injury Work		28d. Describe I	how injury occurred	
Attending Physician: The I add add and add add. ector: After this certificate he by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	Be. Place of Injury - At home, f		fes 2□No	28f. Location (Street and Number or	Rural Route Number,
tal or rs after all Dire	Certi	4 Homicide	building, etc. (Specify)			City or To		
To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Examiner:	 n: To the best of my knowledge On the basis of examination and manner stated. 	ge, death occurred at the tin und/or investigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and o	r as stated. Iue to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	1. 0	29c. License			29d. Date signed (Mo	
0.1		* Claise M =	unes 1	(Time Driet)	4002		1126/6	7
100		30. Name and address of person who complete the second sec	5 22	South G	reene	Stree	9/26/0 + Balh	wars WD
Sta Registr		31. Date filed (Month, Day, Year) OCT 0 2 2009	32. Registrar's agnature	arke				
riegisti	121	7						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 23, 2009 2:55 September Khanthavout /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Apr. 11, 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days 1944 1 M 2 KF Thãi Tánd 164-66-6746 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f shov ral", or items 23a or 28a-f shov 1 ☐ Yes 2 🕅 No **Funeral Director** York Shrewsbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 17361 Thailand 16647 Kennedy Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Exemines 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Completed by Specify: Asian 3 Widowed 4 X Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Khanthavout Not known Seut Boung ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kennedy Cir., Shrewsbury, PA Douangchan Sesum/child 16647 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State Heffner Funeral Chapel 10/03/09 York, PA 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 22. Name and Address of Facility 21. Signature of Funeral Service Licensee William G. Dau 1050 York Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hyperkalemic Cardiac Arrest **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 5 years End stage renal disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Exami Division of Vital Records, P.O. Box 68760, % Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mmths?
1 ☐ Yes 2 MNo 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide n 24 hours aft e Funeral Di letely filled ir 29a. Certifier within 24 hou

To the Fune

completely f Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0064100 9/23/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road; Silver Spring, MD 20910 Smitha Bhikkaji 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Kleinfeld Ward Terry September 28,2009 8:14 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 3501 Mt Zion Road 4b. City, Town, or Location of Death **Examiner** Baltimore Upperco If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days Months 68 1 ▼ M 2 □ F 302-34-4132 OHIO 2/13/1941 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example Transit he reserved any injury or other traumatic event, the Medical Example Transit he reserved. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No **Funeral Director** Baltimore Upperco MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21155 3501 Mt Zion Road USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kleinfeld Edward Becky Moats ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3501 Mt Zion Road Upperco, Maryland 21155 Mary Ellen Kleinfeld / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/3/2009 Towson, Maryland Hilltop Serv. Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Ruck Towson Funeral Home, Maryland 21204 Inc. 1050 York Road Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner Š Completed Be Medical Certification: To 2

To the Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, s been signed by the should be detached

Baltimore, Maryland 21215-0036

After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

esulting in death) Last	Due to (or as a consequ	ence of):			
F FEMALE: 13b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of d 9 Unknown	death 3 Ectopic p			23d. Date of delivery Month Day Ye <i>a</i> r
art II. Other significant conditions of	ontributing to death but not resu	Iting in the underlying c	ause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
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5. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes X ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ DC	OA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	8c. Injury at Work? 1 □Yes 2 □No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, street, factory	, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and place, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifler	tolp m	290	License number	29d.	Date signed (Month/Day, Year)

State Registrar

0 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

		•	For State Registrar	State of Ma	•				lealth and Death	Ment		iene]119	3158
Ī	Physici		1. Decedent's Name (First, Middle, La	se)						M	ate of Death	Day	Yeer 700€	3. Time of Death 2:00P.
	/Medic Examir		4a. Facility Name (If not institution, give FutureCare-Can		or				Location of Dec			4c. C	ounty of Deat	h
	Funeral Director		Social Security Number 6. S		e (In yrs. last birti	hday)_ Yrs.	If Under 1		If Under 24 Hi Hours Mi	S. 8 D:	ate of Birth fonth Day,	^Y 8 ^{ar)} 5	9. Birt Mar	hplace (State or Fore ountry) yland
	ne Maryland 8e-f show	ector	Usual Residence of Decedent 10a. State 10b. County Md •		10c. City, Town		re C		,			0.2		10d. Inside City Lim 1 XYes 2 1
	h with the	Funeral Director	10e. Street and Number 106 South Ellw	ood Aven	ue		10f. Zip (224			11	-	n of What Co U . S . A	•
36	Nore, Maryland 21215-8036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mantal Hygiene. It of Health and Mantal Hygiene. If item 27 is marked other than "netural", or Items 23a or 28e-1 show or other treumatic event, the Medical Examinat must be netitied.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			as Decede Yes, speci		ispanic Origin? an, Mexican, Pue Specify:	(Specify Y erto Rican	C==+**			
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ıland	should be filed vind Mental Hygies marked other umatic event, III	To Be	17. Father's Name (First, Middle, Last Casimir Wdzie	czkowski					18. Mother's N	_ `	Kris		umame)	
Maryland	nd 2 sho alth and h 27 is ma r treuma	ľ	19a. Informant's Name/Relationship (Theodore Kalan		band 10	Mailing	Address S. E	Street a	and Number or a	enue	te Number, e Bal	City or 1	own, State, .	^{Zip Code)} Md. 2122
Baltimore,	More, Pages 1 arent of Hea		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci			у, стет	atory or otl	ner plac		Date 1 - 2 (1		ition - City or	Town, State, Marylan
Baltii	permil. Pages Department of I Importent: If ite any injury or of		21. Signature of Funeral Service Lice		,	22.	Name and	Addres	ss of Facilities a	czoi	ows	i F	unera	1 Home, P Md. 212
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, for con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Corekto	the death. Do note. O ASCO COL. a consequence of	D.						est,		Approximate Interval Between Onset and Death Leave
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Vital	Physicien: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?						26. Place of D				10,100	
of	di S	ည	1 Yes 2 No	Hospital: 1 Inpatie				1000000	4 HT ursing	-			Other (Spe	ecity)
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	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifier				29c.	Licens	se number		2	9d. Date	signed (Mon	th, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

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22

\$508 Glen Borner Many burd 21061

29b. Signature and title of certifier

D19667

10-01-2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

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Division of Vital Records,

		-	State Registrar			,	Cert	ficate of	Death	,	Reg. No.			J 1
	DI.		1. Decedent's Name	e (First, Middle,		1000				2. Date of Dea Month	ath Day	Year	3. Time of Dear	
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	Examin				give street and number)	4		r Location of Deat	h		County of Death altimore		
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	r 28a	Director	10e. Street and Nur	mber				10f. Zip Code			10g. Citiz	en of What Coun	try?	
	th with		42 Land	dmark Co	ourt			21221			U	.S.A.		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evanitation, unit by nutified a once.	by Fu	11. Marital Status 1 🙀 Never Marri 3 🗆 Widowed	ied 2□ Married	12. Was Decedent Armed Forces d 1 Tyes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	? JNo		s Decedent of H es, specify Cub Yes 2⊠No	Hispanic Origin? (an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		4. Race - Americ Black, White, e Specify: Vie		
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State Registrar

			_ For	State of Maryland				lental Hygie	ne	
			1 - State Registrar		Cer	tificate of D	eath	Reg.	No. 1	31583
В	e hysici:	an	1. Decedent's Name (First, Middle, Las	. /				Date of Death Month	Day Year	3. Time of Death
	/Medic		CHIL	LEE				SAT, 2	9 2009	
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			Usual Residence of Decedent							Table is on time
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With th	or2		10e. Street and Number 12345 Fox Meadow	Iama		10f. Zip Code	21794	109.	Citizen of What C	
eath	al', or itama 23e or 28e-f shov Examiner must be multified at	Funeral	12343 FOX PIERUOW	12. Was Decedent Ever in U.	S. 13. V	l		ecify Yes or No-	14. Race - Am	
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should be	mari	ř	19a. Informant's Name/Relationship (7	"ype, Print)	19b. Mailin	g Address (Street an		al Route Number, Ci	ity or Town, State,	Zip Code)
alth a	27 Is		Mark H. Lee - So	n	1234	5 Fox Mead	low Ln.,	West Frie	endship,	MD 21794
es 1 a	itam		20a. Method of Disposition	Damarial from State	emetery, crem	sition (Name of natory or other place,)		. Location - City o	r Town, State
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permit. Departr	Important: if itam 27 is marked other than "natural", any injury or other treumstic event, the Medical Exa once.		21. Signature of Funeral Service Licen	Wahanu N						eral Home at ge, MD 21075
	-		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death	n. Do not ente	er the mode of dying,	such as cardiac	or respiratory arrest,		Approximate Interval Between
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or At	Dirac! in by	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stri y)	eet, factory, office		City or Town, S		Rural Route Number,
spitel	filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, death	occurred at the time	e, date and place,	and due to the caus	se(s) and manner	as stated.
To the Hospitel or Attanding Physician: The law requires that the death certificate within 24 hours after death.	To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	fedical	(Check only 2☐ Medical Exam one)	niner: On the basis of examina and manner stated.		vestigation, in my opi	nion, death occur	red at the time, date	and place, and d	ue to the cause(s)
To	Too	×	29b. Signature and title of certifier	the ms		29c. License	398	7 5	Date signed (Mo	1201-
			30. Name and address of person who 300 ARM OK	4 12,5	v,TE	34 B	ALTI	MORE.	MD 2	1201-
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	aturg &	1				
å.	Registı	ar	OCT 0 2 2009	pereus p. 1	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 09 Harold Anthony Lloyd, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Franklin Square
5. Social Security Number 6. Sex Baltimore If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year)
May 31, 1947 7. Age (In yrs. last birthday, **Funeral** Days Hours **1** M 2 □ F 62 **Director** 218-44-2365 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🕏 No Directo Middle River Balto. Md. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 21220 130 Roundup Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2**X** ☐ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Musician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Elma Bloss Harold A. Lloyd, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4004 Silver Spring Rd. Apt. Bl Nottingham, Md. 2123 DTR. Maria T. Lloyd 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-2-2009 Balto. Md Gardens of Faith 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home cece. 4/10 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ventric Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonai Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Severe Pulmonary Hypertension; Congestive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Heart Failure; Heparin-induced thrombocytopenia, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Right Ventricle Tumor: Lung Tumor: Diabetes Mellitus
25. as case referred to medical examiner?

Hospital: General Communication (Communication) 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

The law been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, $oldsymbol{arphi}$

To the Hospital within 24 hours a To the Funeral I

Medical

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 09.29.09

Alex; M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alex: 9000 Franklin Square Drive: Baltimore MD; 21237 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 10:45 AM 26,2009 September Irene Mary Lowery /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Franklin Square Hospital anter osedale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Apr 17, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔽 F Maryland Apr Director 220-20-2232 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the invalidation is a must be mailed as 1 ☐ Yes 2√ No Director Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 21221 USA 601 Almond AVenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Montgomery Wards bookkeeping 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Casimer Piotrowski Anna REnek ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Amiel Court Towson, MD 21286 Justine Fernandez/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronal S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hemorchage Intracrania (2 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner typerteosion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) attending physician for use as the burial Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 Z No Day Year 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 00055034 9/26/2009 NANUTE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 21237

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 0 2 2009

2330

M.D.

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Robert Lindy Ellsworth McNamee 7:10 PM September 29, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 207 Sunbrook Lane Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 🔀 M 2 🗆 F 215-20-9418 81 2/8/1928 Director Maryland Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experience must be notified an ance of a ponce. 1 ☐ Yes 2 ☑ No Director MD Washington Hagerstown 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 207 Sunbrook Lane 21742 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Advertising Newspaper 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Ellsworth McNamee Mary Elizabeth Mowen ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 207 Sunbrook Lane Hagerstown, MD 21742 Janice McNamee/ Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/1/2009 | Hanover, Maryland Anatamy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licenses 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Box 68760,以 Due to (or as a consequence of) attending physic for use as the b IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. 9 Unknown is certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Division of Vital Records. 1. Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ 1No 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 24 hours af 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

mi

CHIL

Legerstran MA21712

30. Name and address of person who completed cause of death (tiem 23a) (Type, Print)

31. Date filed (Month, Day, Year)

0.2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 25,27 per me, g896, 10702705 dnb, 23ar II

Registrar

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** AM September 9:40 Deborah Mogavero 26 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 219-50-7152 1 □ M 2 🕱 F 57 Director 1-9-1952 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ine Madical Examiner must be notified at Baltimore Director 1⊠Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 U.S.A. 320 S. Eaton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 █No Specify: þ Specify: White 3 ☐ Widowed 4 ₩ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Perdue Pages 1 and 2 should be filed v nent of Health and Mental Hygic int: If Item 27 Is marked other i Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Centerva Adelaide Dombrawski Bernard ဥ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai Nicole Lea Mogavero 568 Bourbon Street Havre de Grace Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Cem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 【3 Cremation 3 ☐ Removal from State 9-28-09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Zannino Jr. F.H. 263 S. Conkling Street Balto. Md. 21224 23a. Part 1. Et le hi dise shock, or le a fail e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** disease or condition resulting in death) a Possibly fulmonary embolism & for arrhythmia /Medical Due to (o as a consequence of) Examiner Due to (or as a consequence of): sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner PROVED BY MEDICAL EXAMINER Pulmonary Ernholism Due to (or as a donsequence of): physician and s the burial-trans CERTIFICATI 68760 Physician/Medical Volume overload attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) ed by the a detached f Records, P.O. 9 Unknown signed be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should imbalance Were autopsy findings available prior to completion of cause of death? 24a. Was an Chronic demyelinating certificate has autopsy 2 No Vital 2 ⊡No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Medical Certification: To 217/10 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA of this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ö the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00068924 September Z6th 2009 Matthew Hams MD 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Johns Hopkins Bayview Medic

32. Registrar's Signature Matthew Harris Baltmore Maryland 21245 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1:02 рМ 19, 2009 September **JOHN** MACK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F August 8, Orangeburg, SC 1918 91 577-24-8954 Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-1 show then tran the tranmatic event, the ModGal Expt. free roughts. In titling at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director Montgomery Silver Spring MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3520 Edwin Street 20902 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be.
Department of Health and Mentail Important: If tiem 27 is marked any Injury or other 2. Be Sadie Adam Mack Armster ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3520 Edwin Street, Silver Spring, MD Leslie Polk/Grandaughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10-01-2009 Suitland, Md Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Licenses 20011 716 Kennedy Street, NW, Washington, DC 23a. Part 1. Enter the disease, or dimplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ACUTE RESPIRATORY FAIL ORE

Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ACIDOSIS METABOLIC physician and s the burial-trans Due to (or as a consequence of): ARRHYTHMIA be Physician/Medical attending for use as 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye ar in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. been signed by the should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed page, 1 ☐ Yes 2 ☐ No certificate 2 **□**1Ño 1 ☐ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 🖫 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending To the Hospital or within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD52855 9-19-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) 0CT 0 2 2009

20770

Chandra S. Korapati, 7207-B Hanover Parkway, Greenbelt, Md

32. Registrar's Signature

Baltimore, Maryland 21215-0036

			State Registrar				Ce	rtificate o	f Death		R	leg. No.	117	510	74	
			1. Decedent's Name (F	irst, Middle	, Last)		-						Year	3. Time of De	eath	
	ysicia Medic		Herodica :	Mende	z					S	optem.	por 28	2009	9.50	PM	
	camin		4a. Facility Name (If no	t institution	give street and nu	mber)		4b. City, Town	or Location of	f Death		4c. County	of Death			
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Fun	neral		5. Social Security Numl		6. Sex		s. last birthday)	If Under 1 Year Months Day	r If Under 2	24 Hrs. 8. Min.	Date of Birth	Year)	9. Birth	place (State or F	Foreign	
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Taryland 21215-0036 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. 1s marked other than "natural" or items 23a or 28a-f show	E.m.	Funeral	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of	f Hispanic Orig	gin? (Specify	y Yes or No-	14. Rad				
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and and n 27	er tr		Erica Rai	mondi		DTR.		1 Wind								
of H	rot		20a. Method of Dispos 1 ☐ Burial 2 ☐ C		0	- 20b.	 Place of Dispose cemetery, cre 	osition (Name of matory or other p	olace)	Date		20c. Location	- City or To	own, State		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglens Innortant; if filem 27 is marked other than "natural", or items 23a or 28a-f show	o Śu		4 □ Donation 5				Io11v H	ills		10-1-2	009 1	Middle	River	- MA		
alti mit. partr	i ji	İ	21. Signature of Funer				2	2. Name and Ad								
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/Med			disease or condition resulting in death)			(or as a conse		ING CH	MUCOC	-						
Exam	iner				540 (0	(0) 40 4 00110	04401100 0171									
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 October рМ Anna Schleps Morris 2:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Tate Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 6, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖺 F Austria 029-28-4751 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?? is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "hadical Examiner must be realfined as 1 ☐ Yes 2 ☑ No Director MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 341 Old Line Ave. 20724 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 white 1 ☐Yes 2 No þ Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Federal Government is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leopold Schleps Anna Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Steven Paul Morris/ Son 341 Old Line Ave., Laurel, MD 20724 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State West Arundel Crem. 2009 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee ten M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 week Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastic Lung Cancer 11 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760 pe Physician/Medical The law requires that the death certificate nding p as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Year Month 5 ☐ Other (specify) ☐Yes 2 No o. the signed by the 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Diabetes Mellitus, Hypertension, Hyperlipidemia Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autonsy performed's certificate 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospice Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) House 1 | Yes 2√2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After or Attending 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital the Funeral TEACHTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061533 10/2/2009 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 8367 Cherry Lane, Laurel, MD 20707 Gulshan Nazir, MD, Registrar

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dical Examir		Ann Sue Metz 4a. Facility Name (if not institution, give street and number) 4b. City, Town, C		4c	. County of Death	
		Frederick Memorial Hospital Frederick				
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	ŀ	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Min. Days C. 1040 Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depended by Depen				
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21215-0036 unld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		Daymar Cn	K	atherine	e Cuzic	
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Sion Attend r death ector:	ह	2 Accident Investigation Sep 29, 2009 1355 hrs 28e. Place of Injury - At home, farm, street, factory, or	ffice building, etc. 28			r Rural Route Number, City
DIVI pital or ours after	Cortification	3 Suicide 6 Could not be determined (Specify) Single Family Home	75	53 Dogwood C	ourt, Frederick,	MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The remain Director: After this certificate has been signed by the attending physicis or on the large of the former of the former director mass 2 should be detached for use as the burit			me, date and place, and di	ue to the cause(s	s) and manner as	stated.
To the Hos within 24 h To the Fun	Modical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated.	pinion, death occurred at t	ine time, date an	d place, and ddc	10 1110 00000(0)
To To	3					
		(arrow HADOON	O.C.M.E.		September 3	
_		30. Name and address of person who completed cause of death (Item 23a)	to of Death Page No.			
10		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 21201			

Registrar

State 31. Date filed (Month Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEPTEMBER 29, 2009 10:20 A.M LOUISE O. MOAN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) PARKVILLE BALTIMORE OAK CREST CARE CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 □ M 2 🗓 F 214-01-7444 2/14/1919 MARYLAND 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 🛛 No BALTIMORE PARKVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8810 WALTHER BLVD. #3613 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) IRMA SCHANZE WALTER MYERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GLYNDON, MD 308 CENTRAL AVE. SHARON KLINE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. GARDENS 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/3/2009 COCKEYSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO1139 21286 TOWSON, MD 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Primary, Stage IV Malignant neoplasm of Liver 12 mos Due to for as a consequence of): Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ► No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Practical Exertine must be notified at once.

Baltimore, Maryland 21215-0036

death certificate be executed burial-trar attending physician for use as the burial Atter this certificate has been signed by the funeral director, page 2 should be detached

Physician/Medical

Completed

Be

Medical Certification: To

Box 68760, Records, P.O. Division of Vital

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

0 V State

Registrar

30. Name and address of person who

4 Homicide

29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Unip MSU R171944

ompleted cause of death (Item 23a) (Type, Print)

and manner stated.

CRUP MIN 8800 Wolther Blvd, Parkville, MO 21234 Harrison 31. Date filed (Month, Day, Year)

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State Registrar		State of M	aryland					0.00	9 91593	
Physicia /Medic			e (First, Midd	Miskill					2. Date of Death Month Septemble	Day Year		
Examine	er	Ba Hime 5. Social Security N	ore h	6. Sex 7.A	ge (In yrs. las		G/ln If Under 1 Year	Report Location of Death Report Signal Signal If Under 24 Hrs. Hours Min.	1e 8 Date of Birth	Anne.	Arundel	
Director		228-20-3 Usual Residence of		IX W ZUF	83	Yrs.			Jan 26,	1926 Vi:	rginia	
aryland show	_	10a. State MD			10c. City, 7						10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate hat completely filled in by the funeral director, page	ertification: T	27. Manner of Deat 1 Natural 2 Accident 3 Suicide	5 ☐ Pendir investi 6 ☐ Could	ng (Month, Di	ay, Year)	Injury	M 1 □				Rural Route Number	
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he Hos in 24 h he Fur pletely	Medical	(Check only one)	2□ Medical	Examiner: On the basis	of examination	n and/or inv	estigation, in my	opinion, death occu	rred at the time, da	ate and place, and de	ue to the cause(s)	
To t with To tl	Ž	29b. Signature and	title of certifie	wallow	M.D.		29c. Licens	8240		1		
		30 Name and addi	ress of person	n who completed cause of	death (Item 2:	3a) (Type, P	rint)	Drive,	6/en.	Burnie,	MD 2/061	
Stat Registra		31. Date filed (Mon	th Day Year	2009 32. Regist	Certificate of Death Reg. No. 2. Date of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death County of Death							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 1.9.15,16a.18,Pt II per phys. & Ant. Bd. G899 State of Maryland / Department of Health and Mental Hygiene 1/5/10 dk State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** /Medical 4a Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WI Soms THINK Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, June 28 9. Birthplace (State or Foreign Country)
-Georgia NC 5. Social Security Number Age (In yrs. last birthday **Funeral** Year) 1938 Days Months Hours 1**∑** M 2 □ F 213-34-5081 71 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1√2Yes 2 □ No Be Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5426 Gist Avenue 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 📆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: black. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Steel Worker
technician 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 44-12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Garnett Mints Mary Lois Scott ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Joyce Blue/daughter 6609 Krone Drive Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronal of S Wade State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 shock Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner reumanic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death
Pregnant at time of death in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Parkinsons Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be patient 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ဂ္ WSILLEY 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) 31. Date filed (Month, Day) 32. Registrar's Signature State 0 2 2009

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			amend #30 FeI DVS	ate of Maryland/1	-	tment of H <i>ificate of L</i>			giene Reg. No. 🥠	990	21600
			1. Decedent's Name (First, Middle, Last)	,				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		FRED MERVIN	MARTIN				Septemb			12:52 PM
	Examin		4a. Facility Name (If not institution, give street	t and number)		4b. City, Town, or	Location of Death		4c. Cour	nty of Death	
war.			Fort Washington Ho	spital			Washingto		Pr	ince G	eorge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h v, Yea <i>r)</i>	Coun	
н	Director		323-10-0303	88	Yrs.			Feb 8,	1921	Mar	yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Loca	ation				1	0d. Inside City Limits
	Maryl f sho	Ď	MD Prince Geo	rge's IIr	nner	Mar1boro)				1 ∐Yes 21∏ No
	the 1	Director	10e. Street and Number	I BC B	PCI	10f. Zip Code			10g. Citizen o	of What Coun	try?
	filed within 72 hours after death with the Maryland thygene. Thygene the work instural", or items 23a or 28a-f show ent, the Medical Ever, her met be neithed a mit to the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in the medical Ever in		Box 788			207	73		U	SA	
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ဖ	or ite		1 Never Married 2X Married	Armed Forces? ☐Yes 2X No		Yes, specity Cuba □Yes 2⊠No	n, mexican, Puerto Specify:	Hican, etc.)		Black, White, 6 cify: whi	
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21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade co		(Give ki	ent's Usual Occupa ind of work done o	lurina most of work	ing	16b. Kind of	Business/Ind	dustry
2	/ithin ne.	du l	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired rgyman)		r	eligio	n
2	led v Hygie her t	ပိ	17. Father's Name (First, Middle, Last)	·	CIC	L G J III CI I	18. Mother's Name	(First Middle			
auc	be fintal hed of	Be	Charles Robert Mari	in			B1anche				
Maryland	hould d Me mark matic	၉	19a, Informant's Name/Relationship (Type:		h Mailing	Address (Street :	and Number or Rur	al Route Numbi	er. City or To	vn. State. Zic	Code)
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiurry or other traumatic event, the Medical Every and the continued once.		Helen Martin/spous	,	3		Marlbor		20773	,,	•
ē,	f Healthean	1	20a. Method of Disposition		of Disposi	ition (Name of atory or other place	0)	Date	20c. Location	on - City or To	wn, State
e E	Pages ent o nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☑ Donation 5 ☐ Other (Specify)	val from State	вгу, степта	atory or other place					
Baltimore,	mit. 3 partm portal r inju		21. Sign tur Funeral S. rv. e Licensee	A Dinastra	22.	Name and Addres	ss of Facility omy Board	655 W	Ralti	more S	Street
m	an)	(3)	1000 1 S. M.	Director			MD 2120		Dares	imoro i	,0200
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one can	ons that caused the death. Do					rrest,	T i	Approximate Interval Between
-	Physician	î î	Immediate Cause (Final disease or condition	Rosein	bre	4	2 /40			1	Onset and Death
	/Medical		resulting in death)	Due lo (or as a consequence)	in the				
and come	Examiner •		Se wentially list conditions b. —	Bulater	a	PNE	u hon	w			
	pe ti	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e or).						
	ecute and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	a of):		<u> </u>				
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×	certif nding ise as	/Me	IF FEMALE: 23c.	f yes, outcome of pregnancy					23d.	Date of deliv	erv
Box	death atter	ciar		1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)	у			Month	Day Year
0	the o	Physician/M	9 Unknown	9 Unknown							
ν. σ.	s that med be e det	by P	Part II. Other significant conditions contrib	uting to death but not resulting	in the und	derlying cause give	en in Part I.				he cause of death?
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ţ	rsician: The law s certificate has b lirector, page 2 sl	BeC	25. Was case referred to medical examiner?				26. Place of Deal				
<u></u>	hysic his ce I direc		1 Yes 2 No Hosp	ital: 1 Mapatient 2 ☐ ER/C	Outpatient		4 LI Nursing H	ome 5 🗆 Resi	dence 6 🗆	Other (Speci	fy)
u u	ng P	::	27. Manner of Death 1 Natural 5 Pending	8a. Date of Injury 28b. (Month, Day, Year)	Time of Injury	28c. Injur Worl		28d. Describe	how injury oc	curred	
sio.	tendi leath. tor: / the fu	cati	2 Accident investigation				Yes 2□No	006	01		al Davida Musebas
Division of Vital Records,	or At ifter d Direct in by	Certification: To	4 Homicide determined	8e. Place of Injury - At home, 1 building, etc. (Specify)	tarm, stre	et, factory, office		City or To		umber or Hur	al Route Number,
	pital		29a, Certifier 1 Certifying Physici	an: To the best of my knowledge	ne. death	occurred at the til	me, date and place	and due to the	cause(s) an	d manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examiner one)	On the basis of examination a and manner stated.	and/or inv	estigation, in my o	ppinion, death occu	rred at the time,	date and pla	ice, and due t	to the cause(s)
	To the To the Somp	Me	29b. Signature and title of certifier	f)a		29c. Licens	e number		29d. Date si	gned (Month,	Day, Year)
			1 Sull H	XV	1	De	D5650	50	9/2	2570	7
,			30. Name and address of person who comp	eted cause of death (Item 23a) (Type, F	Print)			4		
_			Samuel J. Kleimar	Fort Washing	gton	Hospital	l Fort	Washin	gton ,	MD 20	744
I	Sta Registr		31. Date filed (Month, Pax, Year) QCI 0 2 2009	32 Registrar's Signatu	100	MAR					

Division of Vital Records, P.O. Box 68760 ANTHONY MAFALE

4:39 а.ш.

Baltimore, Maryland 21215-0036

SEPTEMBER 28,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Vear **Physician** William A. Marinelli 6:03 PM Sect 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Union Memorial Hospital Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/26/1933 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. New Jersey 1 □**X**M 2 □ F 76 Director 143-26-7093 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified at 1 X Yes 2 □ No MD N/A Baltimore Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21211 830 W. 40th Street # 758 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ YNo Specify: Specify: <u>م</u> 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Staff Director U.S. Gov't Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bedetta Bruna Dominic Marinelli ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Marinelli / Son 4328 Roland Ave. Baltimore, Maryland 21210 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 10/3/2009 Towson, Maryland Hilltop Serv. Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson, Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Ü 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day serzure disease or condition resulting in death) , /Medical Due to (or as a consequence of): **Examiner** Parkinson's pementio 160VZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical thet IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 000 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To hpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 5 Pending investigation 1 □Yes 2 No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 2. 1

P.0.

State Registrar (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Abdallah

OCT 02 2009

29c. License number

AT2438946

Hospital, 201 E. University PLWY, Baltimore, MO

29d. Date signed (Month, Day, Year)

and manner stated.

Union Memorial

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

FRANCIS KHOO.

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

Barket

7601 OSLER DRIVE TOWSON, MARYLAND

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

10a. State

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

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physician als the burial-t the attending pthe

Vithin 24 hours are.

To the Funeral Dir.

dical		d	
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
		ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
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catic	2 Accident investigation	M 1 □Yes 2 □No	La Victoria de la Caracteria de la Carac
Certification:	4 Homicide determined	28e. Place of injury - At nome, farm, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
Medical C		yslcian: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	
Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Them	- MA D46120	Sept 21, 2009
	30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	Col. 6: 120 21247
	21 Date filed (Month Day Year)	32 Registrar's Signature	Colon sia

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25, **Physician** 2009 9:00AM Bonifacio Nieva, Jr. September /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery 2312 Manor Spring Terrace If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 27, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 27, 52 1957 Philippines 218-65-3104 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exercitive must be rediffed at 1 ☐ Yes XX No Silver Spring MD Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Philippines 20906 2312 Manor Spring Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2X Married Asian Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Specify Specify. 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) r and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Medica1 Patient Care Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) Felicidad Nieva Sr. Bonifacio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 20906 2312 Manor Spring Terr. Silver Spring, MD Jennyline Nieva / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/28/2009 Beltsville, MD Chesapeake Crematory Name and Address of Facility

app Funeral and Cremation Services 21. Signature of Funeral Service Licensee M00382 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 2 No 2 No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Hospital 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F

State Registrar

29b. Signature and title of certifier

Nelson G.N. Kalil,

31. Date filed (Month, Pay, Year) 0CT 02 2009

5454 Wisconsin Ave. Chevy Chase MD 20815 St. 1300 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

09/28/2009

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	۾	Armed Forces? 1 Never Married Married 1 Never Married 2 Married 1 Yes, Give 14 Divorced 1 Year or Dates:				EXNo.	No lf Yes, spec					Puerto F	tican, etc.)		Specif	ck, White, y: Wh	ite	
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raum		19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Table 2012)												ip Code)				
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l ler	icat	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)														001 01 114	idi modio man	71001
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DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30. 2000 Month Day **Physician** Platt 014:40M Paul Samuel /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Center OWSON Baltimore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1**⊠**M 2□F 219-18-8381 83 7/7/1926 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminar must be notified at 1 X Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 402 W. Lombard Street 21201 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Barber Barbering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Menta Platt Braun Minnie Joseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any Injury or other trau 3021 Fallstaff Road, Baltimore, MD 21209 Beatrice Starr/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 ☐ Other (Specify) Anatamy Gifts Registry 10/1/2009 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA Sequentially list conditions, Directo for es a consequence of). Examine if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Attending Physician: The law requires icate has been signated page 2 should b 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No Division of Vital 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA
Date of Injury 28b. Time of 28c 1 ☐ Yes After this Certification: To 27. Manner of Death 28a. 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation (Month, Day, Year) Iniury M death. 1 ☐ Yes 2 ☐ No ours after death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fil Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D37254 0

State Registrar BOON POH LIM. M.D. 7601 OSLER DRIVE

Date filed (Month, Day, Year)

232. Registrar's Signature,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 **Physician** 29^{ay} 2009 R. 02:00p ^M Helen Parr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lorien Frankford Nursing & Rehabilitation Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🔀 F 93 04/30/1916 Maryland **Director** 214-50-59**7**6 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a U.S.A. Funeral 2714 Erdman Avenue 21213 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 0, 1 ☐ Yes 2 ☑ No Be Completed by Specify 3 X Widowed 4 ☐ Divorced White than "natural", Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be ment of Health and Mental Mary Injury or other traumatic 2 Lackev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 Department of Health a Important: If Item 27 is any injury or other trau 1022 Boxridge Lane, Essex, MD 21221 Edward J. Parr, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/05/2009 Baltimore, MD Moreland Memorial Park 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee illiandrial blan 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injuly that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 mon Month 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ Ŋ Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation I Director: / 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P. within 24 hours a To the h

> State Registrar

29b. Signature and title of certifie

Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

waltham woods Road MDZ1234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 15:00 PM **Physician** /Medical County of Death . Facility Name (If not institution, give street and numb Location of Death Examiner Montgomer annoch Koaa thesao If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year 8 1**2** M 2□F Min NONE Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State in than "natural", or items 23a or 28a-f show the Medical Experiment must be notified at Montgomer 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 691 RONNOCH 20 Korea Completed by Funeral Was Decedent Ever in U.S. Armed Forces 1
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 4 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify: 181a) 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FINANCE Elementary/Gecondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the angles. (First, Middle, Maiden Şurname) 17. Father's Name (First, Middle, Last) Be NOON YU ဂ္ 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5309 Rando PH RD # 4 Rockville, Mi) 20852 Randolph 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Norbeck 4 Donation 5 Dother (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause o each line. Do get enter the mode of dyir Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s autopsy performed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi reon who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 21,2009 **Physician** 2:58P M September Walter E. Polk, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Balto. Towson Gilchrist Hospice Date of Birth (Month, Day, Year)
September25,1930 Virginia If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral X**□M 2□F Months Days Hours Min. Director 216-24-6509 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Engantment and be motified at 1 ☐ Yes 2 No Director Harford Abingdon Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20 Box Hill South Parkway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 XNo Specify: þ 3√ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Can 9th Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Mendenhall P William Polk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BelAir, Md. 21015 20c. Location - City or Town, State 543 Country Ridge Circle Walter E. Polk, Jr. Son 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 10-3-2009 Balto. Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home all 21236 9705 Belair Rd. Nottingham, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER SQUAMOUS CELL TONGUE **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examine nding physician and ise as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has I autopsy perform performed? 1 ☐ Yes 2 □No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Mother (Specify) \(\text{HOSP(CE)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Pwithin 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D64395 SEPTEMBER 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 6701 N CHARLES ST, SUITE 4105 BALTIMORE, MD 21204

Registrar DHMH 17 Rev 1/2001

State

DANIEUE DEBERMAN, MO

31. Date filed (Month, Day, Year)

2009

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 29 09 O /Medical 4a. Facility Name (It no t i**p**stitution, give street and number, 4c. County of Death Examiner timore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F South Director CArclina Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 No Completed by Funeral Director Street and Number Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 21215-0036 1 □Yes 2 No 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Givekind of work done during most of working life) DO NOT use refred)

CONG Shotte man 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maryland 17. Father's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Sarname Be 1/en ۵ other t ortant: If item 2 Injury or other Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other plants) 20a. Method of Disposition Location - City or Town, State Pages 1 ō 1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department o Important: If any Injury or 3 Pemoval from State 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SEPH ON. FULTON AVE. BA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** End disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner por ens Sequentially list conditions if any leading to have date cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \Bursing Home Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type

DHMH 17 Rev 1/2001

State Registrar MD

31. Date filed (Month, Day, Year)

1000

32. Registrar' Signat

4a. Facility Name (If not institution, g 8900 Robin Place 5. Social Security Number 039-28-6857 Usual Residence of Decedent 10a. State 10b. County	George's 12. Was Decedent Ever in U.S. Armed Forces? 1 X Sex 12. Was Decedent Ever in U.S. Armed Forces? 1 X X Ses 2 No 1964 If Yes, Give Year or Dates: -1968 Education grade completed) College (1-4or 5+) Depth	Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Interest Int	If Under 24 Hrs. 8. Date of (Month, July) Hispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify: Dation during most of working d)	10g. Citizen of What Course American Black, White Specify: W	Seorge's Implace (State or Foreign Jode Island 10d. Inside City Limits 1
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5. Social Security Number 039-28-6857 Usual Residence of Decedent 10a, State 10b, County MD Prince 10e. Street and Number 8900 Robin Place 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of Specify only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only highest only	Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Table Tabl	If Under 1 Year Months Days or Location 10f. Zip Code 20708 13. Was Decedent of Inf Yes, specify Cubin Uyes 2 XIXIo Decedent's Usual Occup Give kind of work done life. DO NOT use retiren	dispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify: Dation during most of working d)	Birth Day, Year) 9. Birth Co. L8, 1946 Rhc 10g. Citizen of What Co. U.S.A. No. 14. Race - Ame Black, White Specify: W. 16b. Kind of Business/	thplace (State or Foreign bunty) Jean 10d. Inside City Limits Lyes 2 No buntry? prican Indian, e, etc.
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IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of de	elivery
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nthony Reid	1-	State of Maryland / Department For State Certificate	of Death	ygierie Reg. No	20	0 016
Physician/	R	gistrar Decedent's Name (First, Middle, Last)	0, 2000.	2 Date of Death	3	Time of Death
ledical Examine	er	Anthony T Reid	The state of Dotte	Month Day September 26,	c. County of Death	2101 hrs
	4	a. Facility Name (if not in titution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore		NA	
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24Hrs Months Days Hours Min		1-	olace (State or
Director		104-60-3180 1 XM 2 = 32	Yrs. World's Bays Hears	Den / 1	971 Cour	itry) ca Jork
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th the Maryland 23a or 28a-f sho notified at once		0e. Street and Number	/10f. Zip Code	log. C	// SA	ıy:
be filed within 72 hours after death with the Maryland ntal Hygiene. Treed other than "natural", or items 23a or 28a-f site ent, the Medical Examiner must be notified at once the Proposition of Natural Dispersor			Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - America White, etc.	an Indian, Black,
or items	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Specify: Bla	· 1.
s after ral', o	≥ -	3 Widowed 4 Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) 16a. Dec	Yes 2 No specify: edent's Usual Occupation (Give kind of	work done 16b	. Kind of Business/In	dustry
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oo36 within and ene.	ᇍ	/2	MOVRY 18 Mother's Nam	e (First, Middle, Maide	ruckir en Surname)	~g
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212 hould be nd Ment is mark		19a, Informant's Name/R ationship (Type Pont) wother 19b. N	Mailing Address (Street and Number or	Rural Route Number,	City or Tow , Sta e,	Zip Code)
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Baltim. Sermit. Pag Department Important:	ŀ	4 Donation 5 Other Specify:	22. Name and Address of Scility	is Funera	e service	KA.
Det Det ili		23a. Part In the disease, or complications that caused the death. Do not e	inter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval
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3760 ificate l		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg		23d. Date of delivery Month	y Day Year
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	past 12 months? 4 Pregnant at time of death 5	Other (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.		Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did toba	cco use contribute to	
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. An Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	Completed		CD at CD	1 🗸 Yes 2	No 1 ✓ Y	es 2 No
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Jivis al or Al safter of Direct	Certification:	Suicide 6 Could not be determined (Specify) Interstate/Expres	m, street, factory, office building, etc.		e) 5 @ MM 52.8, Balt	
Division Division Hospital or Attend 24 hours after death. Funeral Director:		29a. Certifier a Contituing Physician: To the best of my knowledge deat	h occurred at the time, date and place, a	and due to the cause(s) and manner as sta	ted.
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre 29c. License number		a place, and due to t	
	ž	29b. Signature and title of certifier	O.C.M.E.	ļ.	September 29,	
		30. Name and address of person who completed cause of death (Item 23a)				
5√		Ling Li, MD Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201			
	ate	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	back			
Regist		00100	GINAL			

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		in y lanta /	Cer	tificate of	Death	Work at 11	Reg. N	.2009	31611
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	rdea	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of h	lispanic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	io-	14. Race - Ame Black, White	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Maralcal Examina	Completed by Fi	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 □Yes 2 ☑ N If Yes, Give Year or Detes:	lo		□Yes 2∑No					nite
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an	d be ental ked o	To Be	John Bauschek	,					n Marie			
Maryland	shoul ind M i mar	-	19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailin	g Address (Street	and Number or F	Rural Route Num	ber, City	or Town, State, Z	Tip Code)
ž	alth a 27 is 27 is r tra		Kathi Rintoul Ha		er 9	702	Stoneham	Terrace	, Bethes	sda,	Marylan	d 20817
Baltimore,	bages 1 a ent of He nt: If Item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		20b. Place ceme	of Dispos tery, cren	sition (Name of natory or other place Crematorium	ce) Sep	Date	20c.	Location - City or	Fown, State
Baltii	permit. Pages 1 and 2: Department of Health a Important; If Item 27 is any Injury or other trau		21. Signature of Funeral Service Lice		M01305	- RO	Name and Addre	ess of Facility	eral Home	/ Betl	nesda-Chev	7 Chase, Inc.
				nolications that caused	the death. D						yland 2081	
V	Physician		23a. Part 1. Inter the disease, or cor shock, or heart failure. List only Immediate Cause (Final				,	3,	,			Approximate Interval Between Onset and Death 2 Months
	/Medical		disease or condition resulting in death)	Due to (or as		e of):						2 FIOREITS
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Division of Vital Records,	ing After une	ion	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 280	. Time of Injury	Wor		28d. Describe	how inj	ury occurred	
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Ω	tal or / rs after al Dire ed in b	Certification: To	4 ☐ Homicide determined	28e. Place of Inju building, etc	. (Specify)				City or To	wn, Sta	te)	na riodic rumoci,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1	hysician: To the best of miner: On the basis of and manner sta	examination	lge, death and/or inv	occurred at the ti restigation, in my	me, date and place opinion, death occ	ce, and due to th curred at the time	e cause e, date a	(s) and manner as nd place, and due	stated. to the cause(s)
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Registrar DHMH 17 Rev 1/2001

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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Maricell Experiment must be notified at once.	To Be Completed by Funeral Director	MD
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Baltimore, Maryland 21215-0036	tural	ed k	304
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To the Hospital or Attent within 24 hours after death To the Funeral Director: by the

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Division of Vital Records,

ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Seinwill .ly Wagner 7:10 PM September 28, 2009 ty Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Calvert Chesapeake Drive Lusby Park If Under 1 Year Security Number If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Months Days Hours 1 □ M 2 🕅 F -38-7544 69 6/26/1940 Wisconsin sidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Calvert Lusby et and Number 10f. Zip Code 10g. Citizen of What Country? 20657-4037 U.S.A. 0 Park Chesapeake Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. al Status lever Married 2x Married 1 ☐Yes 2 ☑No White Specify: Vidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ntary/Secondary (0-12) College (1-4or 5+) 12 Therapist Education Speech r's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudesill С. Wagner Roselyn rmant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ald Seinwill/ Husband 2390 Park Chesapeake Drive, Lusby, MD 20657-4037 nod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 9/30/2009 Anatomy Gifts Registry Hanover, Maryland Oonation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Approximate Interval Between Onset and Death t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause un each line. ite Cause (Final or condition in death) ON CIPOH IC (av)(P) morts Due to (or as a consequence of) ially list conditions, ading to immediate -nier underlying Disease or injury ated events in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) Physic 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 ☐Yes 21 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature) and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) meisenberg 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) enberg 31. Date filed (Month, Day, OCT 02

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Colonber of Jacop 1:35

4c. County of Death
Balt. County Year heppar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown NorthWest Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, 6/11/52 9. Birthplace (State or Foreign Scountry) **Funeral** Days Hours 218-60-3606 **№** M 2□ F Director Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore Gywnn Oaks 1 Yes 2 No Director 10g. Citizen of What Country? 10f Zip Code 21207 10e. Street and Number 7201 Campbell Road Funeral 14. Race - American Indian, Black, White, etc. African SpecifyAmerican 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 □ No Specify: Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Mamied altimore, Maryland 21215-0036 δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DQ NOT use retired)
Laborer 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Construction Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname)
Louise Simmons 17. Father's Name (First, Middle, Last) Leonard Sheppard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louise Koger/Mother 7201 Campbell Rd, Gywnn Oaks, MD 21207 20b. Place of Disposition (Name of cemetery crematory or other place)
King Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Balt.County,MD 10/8/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Plune al Sen ce Licenses e, er complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Unseed or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 2□ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide EcertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical €

4 State

Registrar

31. Date filed (Month, Day, Year) OCT 0 2 2009

30. Name an

29b. Signature and title of certif

dress of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

29c. License number

5401 Old Court RD Randall tought 21135

29d. Date signed (Month, Day, Year)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia		For Amend Items 25 State Registrar 1. Decedent's Name (First, Middle, Last)	ciste of 8 Nath la	ped/Depa Cei	g stocento rtificate d	02705411 of Death		Reg. No.	3. Time of Death					
/Medica Examine Funeral	r	4a. Facility Name (If not institution, give structure) 5. Social Security Number 6. Sex 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. Age (In yi	rs. last birthday) Yrs	BALT		Hrs. 8. Date of Birt (Month, Da)	4c. County of h y, Year) 9	Death Birthplace (State or Foreign Country)					
Director	ō	Usual Residence of Decedent 10a. State 10b. County MD	10c. 0	Yrs. City, Town or Lo	ocation		07/13/1	936	VA 10d. Inside City Limits 1X1Yes 2 □ No					
036 urs after death w ur', or items 23a	by Funeral Director	10e. Street and Number 711 W. SARATOGA		U.S. 13.	10f. Zip Co	2120 of Hispanic Origin Cuban, Mexican, P		10g, Citizen of What 14. Race - Black, Specify B1	USA American Indian, White, etc.					
ind 2121 be filed within ttal Hygiene. d other than " event, In Ma	lo be Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last) RAYFIELD SMITH SR	om <i>pleted)</i> College (1-4or 5+)	(Give	dent's Usual O kind of work d DO NOT use re CK DRIV	one during most of etired) ER	Name (First, Middle,	Maiden Surname)	DFFEE POT					
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once.		19a. Informant's Name/Relationship (Type VILLA SMITH/WIFE 20a. Method of Disposition 1 Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	20b	Place of Dispo cemetery, crer	711 W. Desition (Name of matory or other ORIAL P. 2. Name and A	SARATOGA of place) K 8-2 ddress of Facility	JAMES A.	O., MD 21 20c. Location - Ci BALTIMORI MORTON &	ty or Town, State E, MD SONS F.H., INC					
Physician /Medical Examiner	ca	Physician/Medical Examiner	ical Examir	Ical Examiner	Ical Examiner	Ical Examiner	23a. Partyl Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, day, leading to financiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cause on each line.	equence of):	ter the mode of	f dying, such as ca		rrest,	Approximate interval Between Onset and Death
O. Box 68 the death certificate the attending phyched for use as the							IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ∐Yes 2 □ No 9 □ Unknown	. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	⊒ Ectopic pregi ⊒ Other <i>(specit</i>			23d. Date Monti	
I Records, The law requires thate has been signe	Completed by Pn	Part II. Other significant conditions contributions Contributions Subdum	buting to death but not not not not not not not not not no	esulting in the u	nderlying cause	e given in Part I.	1 🗆 1	res 2 No 3 an 24b. We prive the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont	ute to the cause of death? Probably 4 Unknown ere autopsy findings available or to completion of cause of ath? Yes 2 No					
of Vita hysician this certifi	Certification: 10 Be	27. Manner of Death Section Pending Investigation	pital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) Unknown 28e. Place of Injury - At building, etc. (Spe	28b. Time o Injury Unkno	of 28c.	Other: 4 Nursi Injury at Work? 1 Yes 2 No	Death (Check only of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the probable of the prob	dence 6 Other now injury occurred e multipl Street and Number						
To the Hospital or within 24 hours an To the Funeral Dir completely filled in	Medical Cert	29a. Certifier 1 ertifying Physic	Found: Nuclear: To the best of my ker. On the basis of exam and manner stated.	rsing H	th occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at the occurred at	he time, date and	Fayette place, and due to the occurred at the time,	Street, I cause(s) and man	Saltimore, MD ner as stated. d due to the cause(s)					
Stat Begistra	e	30. Name and address of person who com Howard B. C 31. Date filed (Month, Day, Year)	pleted cause of death (II	tem 23a) (Type,	Print) Park	Hghts	Ave. B	Ho, Mi	21215					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 29, 2009 **Physician** P^{M} Homer Smith 9:15 Robert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Denton Caroline Envoy of Denton Nursing & Rehab. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ▼ M 2 □ F 219-05-6390 Maryland 06-11-1920 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No **Funeral Director** Maryland Greensboro Caroline 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with United States 12019 Knife Box Road 21639 12. Was Decedent Ever in U.S. Armed Forces? 1 哲学s 2 □ No 194 If Yes, Give Year or Dates: 194 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1942-1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify. Specify: Completed by 1945 White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than Truck Driver Transfer Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Osborne Jesse L. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other tra once. Jesse L. Smith - Son 1614 George Avenue, Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. Oct. 2, 2009 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at A.1 Stoll MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician aspiration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner advenced Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2☐No 3☐ Probably 4☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA ို After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)' 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D005325 2 30. Name and address of person who completed cause of death (Item 2004 (Item 2004)). Preston MD 21655 134 Melma 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 02 20 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** p^{M} Bernard 09 29 W. Shannahan 2009 04:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Brooklandville Brightwood Center 8. Date of Birth Month, Day, Year July 4, 1927 Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs 1 X M 2 □ F 82 Maryland 214-26-2889 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Modical Examinat must be notified at 1 ∐Yes 2XX No Director MD Parkville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8707 Littlewood Road 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2/X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager <u>Crane Company</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Shannahan Katherine Armstrong Department of Health and Important: If item 27 Is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Shannahan / Wife 8707 Littlewood Road Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 2009 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed' 2 No 2 1 NO 1 □Yes 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical vexaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

within 24 hours after To the Funeral Direct

Medical

4 🗌 Homicide

(Check only

GRACITO

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. PATRICIO

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

0008358

8903 HARFORD Rd. DALTIMORE MARYLAND 21234

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 27 Month Year **Physician** 2009 anders 12:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number) Examiner Nursing Jardens If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days -9708 1 M 2 F Yrs Nort Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Nes 2 No Funeral Director altimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 ☐ es 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Blac Completed by 3 Nidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Denjamin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any Injury or other trau once. Saltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 21243 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Uniscale or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Other: 1 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death Natural 28a. Date of Injury (Month, Day Year, 28b. Time of To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) OCT 02 2009

8813 Waltham Wards Rd, Suite 204, Parleville MD 21234 Prajapati 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0069314

10,01,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 09-30-2009 Physician/ 12:48 AM Linda Shapray Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 09-04-1945 1 M 2 V F 64 GA 256-72-3657 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Yes 2 No SC Richland Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 29229 USA 14 Staunton Ct items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces? ò à 1 Never Married 2 Married 5-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Ith and Mental Hygiene.
27 is marked other than "r Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Verizon Wireless Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lucile Bradford Page 1 and 2 should be in ment of Health and Menta ant: If item 27 is marked Raymond Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1023 E. MacPhail Rd Bel Air, MD 21015 Dolores Lewis (Sister) Important: If item 27 any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 10-01-2009 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir 610 W. MacPhail Rd Bel Air, MD 21014 linc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law equires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Day Year Pregnant at time of death 5 Other (specify) theen signed by the should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown has been 24a. Was an autopsy

Completed page 2 s director, Be ٥ the funeral Certificate: within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera

a.m.

12:48

SEPTEMBER

LINDA SHAPRAY

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes 2 No

25.	case n	eferre	d to medical
	Yes	2 X	No
0.7	Yes		No

1X Natural

(Check only one

Hospital 28a. Date of injury (Month, Day, Year) 5 Pending

Other: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at iniury

26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28d Describe how injury occurred

3	Suicide Homicide	6 Could not be determined	28e. Place of Injury - building, etc. (Sp
29a.	Certifier	1 Certifying Physici	an: To the best of my k

work? 2 🗌 No At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)

TIMONIUM, MD 21093

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b.	_		of contifier WellNP	
30. 1	lame and	address	of person who completed cause of death (Item 23a) (Type,	Print)

29c. License numbe

29d. Date signed (Month, Day, Year) 2009

- 1	674	
	Sta	te

Medical

JACKIE JONES, CRNP 31. Date filed (Month, Day, Year)

registrar's Signatu

2300 DULANEY VALLEY RD.

15

this

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend 29a & 30 per DVR g896 10/2/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10:30 A. Liselotte Hedwig Strateff September 20,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Deborah Assisted Living Montgomery Derwood If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 271-34-9650 84 4, Director Nov. Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ira Medical Evanting must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Montgomery Derwood 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17725 Cliff Bourne Lane 20855 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilhelm Joseph Greissinger Hildegard Georgina Bley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristina S. Moore/Daughter 3332 Silver Crest Road, Nazareth, PA 18064 20b. Place of Disposition (Name of cemetery, crematory or other place)
Georgetown University 20a. Method of Disposition 20c. Location - City or Town, State Date Sept. 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 onation 5 Other (Specify) Medical Center 2009

22. Name and Address of Facility Columbia Mortuary Services, P.A. 2009 Signature of Funeral Service Licensee TUlave 9013 Annapolis Rd., Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3

Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ■No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1955 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident (Month, Day, Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Vinu Ganti, MD 19529 Doctor' sDrive Germantown, MD 20874

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) OCT 0 2 2

2. Registrar's Signature

			For State Registrar			State of	Marylar			nt of H		and Me	_	giene Reg. No.	2009	31523
	Physicia		1. Decedent's Nam	ne (First, Midd	le, Last)							2	2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		SHA	ARON	ANN	SAUN	IDERS						Septemb	per 30	2009	12:35 p ^M
· P	Examin	er	4a. Facility Name ('If not institutio	n, give st	reet and numb	er)		4b. Cit	y, Town, or	Location of	of Death			ounty of Death	
			UPPER C 5. Social Security N		AKE 6. Sex			ER last birthday	/) If Und	BELA ler 1 Year		24 Hrs. 8	B. Date of Bir	th	ARFORD 9. Birth	CO place (State or Foreign
	uneral irector		219-60-63 Usual Residence of	397		м 2 XX F		4 Yrs.	Month	s Days	Hours	Min.	(Month, Da MAY 25	ay, Year)	Cou	ntry) YLAND
land but	M III		10a. State	10b. County	,		10c. Ci	ity, Town or I	ocation.			·				10d. Inside City Limits
1435 PM death with the Maryland	items 23a or 28a-f show arrnust be notified at	ţo	MARYLAND	HAR	FORD	CO				EDGE	WOOD					1 □Yes 2X□No
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or dea	or items 23a	Funeral	11. Marital Status			2. Was Decede Armed Force	es?	J.S. 13	. Was Dec	edent of Hoecify Cuba	ispanic Ori in, Mexicar	igin? (Spec n, Puerto Ri	ify Yes or No ican, etc.))- 14	 Race - Ameri Black, White, 	
	al", or	þ	1 ☐ Never Marr 3 ☐ Widowed			1 ∐Yes 2 If Yes, Give Year or Date			1 □Yes	2 X No	Specify:			s	pecify: BLA	CK
5-0 72 hc	natu	etec	(Spec	15. Deceder	nt's Educa	ation completed)		16a. Dec	edent's Us	sual Occup	ation during mos	t of working	,	16b. Kind	of Business/Ir	ndustry
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'ylal ould b Ment	arked atic e	2	JOHN E	E. COPE	LAND							MARIE	COPE	LAND		
2 sho	is m		19a. Informant's N	lame/Relations	ship (Typ	e. Print)			_						Town, State, Zi	
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Depa	any i		21. Signature of Fu	unera Service	proensee			1	JTT.T.T	AM C	ss of Facilit BROWN LADEI	I COMM	I FUNE	RAL HO	OME-HAR DEEN,MD	FORD, P.A. 21001
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s that	ned t	by Pr	Part II. Other signi	ificant conditi	ons cont	ributing to dea	th but not res	sulting in the	underlying	cause give	en in Part I		23e. Did	tobacco use	e contribute to	the cause of death?
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Attending P	To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: To	27. Manner of Deat 1 Natural Accident	5 🗌 Pendi	ng igation	28a. Date of (Month,	Injury <i>Day, Year)</i>	28b. Time Injury		28c. Injur Work	yat <br Yes 2 □		3d. Describe	how injury	occurred	
or Atter	irector in by the	rtifica	3 ☐ Suicide 4 ☐ Homicide	6 □ Could detern		28e. Place of building	Injury - At h	L ome, farm, s ify)	treet, facto	ory, office		28		(Street and wn, State)	Number or Ru	ral Route Number,
Hospital or Attending 44 hours after death.	ineral D		29a. Certifier (Check only	1 Certifyi	ng Physi	clan: To the b	est of my kn	owledge, de	ath occurr	ed at the tir	me, date a	nd place, a	nd due to the	e cause(s) a	and manner as	stated.
the Ho	the Fu	Medical	one)			er: On the bas and manne	r stated.	alion and/or				atti occurre	u at the time			to the cause(s)
To t	COU	≥	29b. Signature and	title of certifie	er A 🔷				2	29c. Licens		1010	,	-	signed (Month	
				Ya		· .						6912		UCT	ober	1,2009
	12		30. Name and add	ta Po	wno con	ipleted cause	or death (Ite	m 23a) (Type	Atuan	mand 1	Qd .<	XAHD	2 R	el A	ic M	0 21014

State Registrar

			for State Registrar		o. many rain	•	tificate of I		Mental Hy	Reg. No.	09 3162	No. of Contract
ľ	JIE		Decedent's Name (First, Mide	dle, Last)					2. Date of De	eath	3. Time of Death	-7
	Physici /Medic		Harbans Sin	αh					Month	Day ember_30,	Year 2009 1:55 PM	N
	Examin		4a. Facility Name (If not instituti		umber)		4b. City, Town, or	Location of De		4c. County of		
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10,	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 H		rth av. Year)	Birthplace (State or Foreign Country)	дп
	Director		215-23-6417	1⊠M 2□F	94	Yrs.	Montals Days	Tiodio IVII		4, 1915	India	
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	anyla shov d at	<u>.</u>	10a. State 10b. Count	ty	Toc. City	, TOWN OF LO	cation				10d. Inside City Limit 1 ☐ Yes 2 🔀 N	
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	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	<u>ra</u>	18908 Impulse			1	20879			India	A	
	er de	Funeral	11. Marital Status	Armed I		S. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Ongin? an, Mexican, Pu	(Specify Yes of Netro Rican, etc.)	Black	- American Indian, , White, etc.	
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<u></u>	2 should b and Ment is marked raumatic e	F	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailin	g Address (Street a		-	per, City or Town, S	State, Zip Code)	_
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altillior	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic esone.		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other		n State		natory or other plac		Oct 03,	Bolterri	lle, Maryland	
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٥	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	e birth 2□Fetal gnant at time of de		JEctopic pregnancy] Other <i>(specify)</i>			Mon	th Day Year	
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VII I	/sician: The law s certificate has bi director, page 2 sh	Be	25. Was case referred to medic examiner?	Hospital:	□Inpatient 2□	ER/Outpatien	t 3□ DOA Oth		24a. Wa: auto perl 1∐ Yes	s an 24b. Wopsy porned do 2 No 1	Vere autopsy findings availab rior to completion of cause of eath? □ Yes 2□ No	e le
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day September 28, **Physician** 7:55 P M Norris William Shank 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville

1 Vear | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Shady Grove Adventist Hospital Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 69 Yrs. If Under 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 ☐ F 207-30-4544 May 11, 1940 Michigan Director Usual Residence of Decedent the Maryland 10d. Inside City Limits show 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mast by notified at once. 1 ☐ Yes 2 X No Director Maryland | Montgomery North Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15513 Summer Grove Court 20878 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ∏Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Investments Financial Planner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph William Shank Julia Vassart 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15513 Summer Grove Court, North Potomac, Maryland 20878 Gail W. Shank/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition October 3, 22. Name and Address of Facility Robert A. Pumphrey Fuenral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 20 M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock days /Medical Due to (or as a consequence of): Examiner Acute Cholecystitis 2 days Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) I □Yes 2 □No P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ cate has been signated by page 2 should b 1 X Yes 2 No 3 Probably 4 Unknown Ischemic Heart Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0061382 September 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shama Mittal, 14816 Physicians Lane #152, Rockville, Maryland 20850

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year SELLS **Physician** AVMOND SEPTEMBER 29 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lutherville Baltimore 107 Ridgefield Road If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Year Months 1 X M 2 □ F 85 West Virginia 234-26-2265 June 14 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be refilled at appear. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 X No Director Baltimore Lutherville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 107 Ridgefield Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +2 Sales Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bitzer Sells Zona Elmer R. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Ridgefield Rd. Lutherville, Md. 21093 Mrs. Mary M. Sells/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 10-5-09 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funetal Serv e Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) MUDCARDIAL **Physician** MINUTES /Medical Due to (or as a consequence of): Examiner MERROSCLERUSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy performe 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred medical Be 26. Place of Death (Check only ope) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

1541

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ER, CJ, CARR, MS / TEXAS STATION B. #210 Timonium, MARYLAND 21093

31. Date filed (Month, Day, Year)

32. Registrar's Signature

32. Registrar's Signature

053095

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7:04 A M Schult September 29 2009 Helen Haase /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Greater Baltimore Medical Center
5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jul 3, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖬 F 75 Pennsylvania 208-28-8978 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Examination must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21093 9 Cromer Court #102 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1∐Yes 2∭XNo Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sectretary Auction House 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Buckingham Alfred Haase ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Cromer Ct # 102 Timonium, MD Robert R. Schult-husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 10/01/09 Hilltop Serv Corp Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LOKONARY Physician /Medical Due to (or as a consequence of): OBSTRUCTIVE PULMOMERY DISKUE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physician Physician/Medical as the b 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2.2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

or Attending Physician; The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, this death. within 24 hours after death To the Funeral Director: filled in by the Hospital completely

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

ca

29a. Certifier

(Check only one)

29b. Signature and title Coertifier

31. Date filed (Month, Day, Year)

HAMISI

0 2 2009

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

P50232

CIDGEBROOK DO STE 312 SPANKS MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 29 2009 Physician/ 11:55 am Rennert Μ. Smelser, M.D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Towson Gilchrist 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) **Funeral** Ap (Many), 13, Yeal)923 Months Days Hours 1**火** M 2 □ F Mary and 86 220-14-1807 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director Lutherville Baltimore 1 Tes 2 No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral USA 21093 18 Oakridge Court or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumasis. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Medical Physician/ Surgeon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Anna Marquette Lambert Μ. Smelser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Oakridge Court Lutherville, Md. 21093 19a. Informant's Name/Relationship (Type, Print) Mrs. Elizabeth B. Smelser/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 10-3-09 Westminster, Md. Baust Emmanuel Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Townson Funeral Home, 21. Signature of Funeral Service License 1050 York Rd. Towson, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ADENOCARCINOMA OF UNENOWN PRIMARY WEEKS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (u. as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available ATRIAL FIBRILLATION Was an autopsy performed prior to completion of cause of CHRONIC LYMPHOCYTIC LEUKEMIA 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural (Month, Day, Year) injury 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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9MELSER

State Registrar only one

29b. Signature and title of certif

DANIEUE DOBERMAN, MD Aegistrar's Signature 31. Date filed (Month, eneur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N CHARLES ST, SUITE 4105

29d. Date signed (Month, Day, Year)

BALTIMONE, MD 21204

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 29, 2009 Physician 11:57P M **SCHLOSSBERG** ROBERT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL 3440 LAUREL FORT MEADE ROAD LAUREL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 3irthplau Country) NJ 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 X M 2 □ F 57 03-10-1952 Director 143-48-6115 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macinal Examiner must be notified at LAUREL 1 □Yes 2 No ANNE ARUNDEL MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20724 3440 LAUREL FORT MEADE ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SALES SUPPORT LOTTERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SCHWARTZ ALBERT SCHLOSSBERG FLORENCE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) MICHAEL PIERSON/BROTHER-IN-LAW 9 SEWARD DRIVE, WAYSIDE, NJ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State BETH ISRAEL 10-01-2009 WOODBRIDGE, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Years **Physician** Ischemic /Medical Due to (or as a consequence of): **Examiner** ongestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nensequence of) Examiner and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 After this certificate 1 □Yes the Hospital or Attending Physician; 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be examiner: 1 ∐ Yes 2 No Other: 4 \sum Nursing Home Hospital: 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D56797 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ALITHA

TADIKONDA 2. Registrar's Signature

DHMH 17 Rev 1/2001

13952 BALTIMORE AVE, LAUREL,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 30, 3. Time of Death 2009 1:55 A M Eugene (nun) Todd September 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 1517 East Wheel Road Bel Air Harford 8. Date of Birth (Month, Day, YADr. 29, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 5. Social Security Number Months Days Hours Min. 1**X** M 2 □ F 87 1922 Virginia 218-12-2140 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1517 East Wheel Road 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 📉 No Specify: Specify: 3X Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator Dairy Farm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carl (nmn) Todd Eva Grace McKnight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cara T. Blount / Daughter 1519 East Wheel Road, Bel Air, Maryland, 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 StrBurial 2 ☐ Cremation 3 Removal from State 10/3/2009 Bel Air Memorial Gdn. Bel Air, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signat As I Fundral Service Lice 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lune disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Disc to (or as a consequence of tany, leading to firm edia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans attending pl for use as t After this certificate has been signed by the funeral director, page 2 should be detached within 24 hours after death

To the Funeral Director: filled in by

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

t of Health

9

Department of Important: If any injury or once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

with the Maryland

bv

31. Date filed (Month, Day, Year) State

Ashkan Bahrani,

6 Could not be

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 0

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

602 S. Atwood Road, Suite 200, Bel Air, MD 21014

OCT 02 2009

Registrar

the Hospital or Attending Physician: Division hours after death.
uneral Director: ,
y filled in by the fi within 24 hours a completely

Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 27, 2009 O.C.M.E. repente 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

Medical

State Registra

one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State of Maryla	•	irtment of Hea tificate of Dea			eg. No. 🤈 🔒	00 3163	2
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Samuel Locke Thomsen Jr				2. Date of Deat	Day	3. Time of Death	N
~-	Medic Examin	_	4a. Facility Name (if not institution, give street and number) 636 ST. JOHNS RJ.		4b. City, Town, or Local	ation of Death		4c. County		┨
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s, last birthday) o Yrs.	If Under 1 Year If U	Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthplace (State or Foreigr Country) Maryland	ın
	Director		Usual Residence of Decedent	0			Nov 25,	1920		\exists
	aryland ta-f sho ified at	Director	10a. State 10b. County 10c. (City, Town or Loc	imore				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	a or 28 be not	ä	10e. Street and Number	Dait	10f. Zip Code			10g. Citizen of W		ヿ
	th with ms 23 must	Funeral	636 St. Johns Road	U.S. 12 V	212 Vas Decedent of Hispar		rify Yes or No-		SA e - American Indian,	-
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 25a or or 28a-f sho raumatic event, the Medical Examiner must be notified at	<u>ج</u>	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☒ Yes 2 ☐ No	If	Yes, specify Cuban, M	lexican, Puerto F	Rican, etc.)	Blac	white, etc.	
15-0	72 hour	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation aind of work done during O NOT use retired)		g unk	16b. Kind of Bu	usiness Industry	
212	within giene. ger thar the M	S	Elementary/Seconday (0-12) College (1-4 or 5+) 0	ille. DC	JNOT use retired;			payro1	1 acct	\Box
land	l be filed lental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Samuel Locke Thomsen Jr			. Mother's Name Adelade	, ,	Maiden Surname	a)	
Mary	should h and N 7 is ma rraumat		19a. Informant's Name/Relationship (Type, Print) Samuel Thomsen III/son		g Address (Street and I					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			o. Place of Dispos	Pickett Ro sition (Name of natory or other place)		erviile		1093 - City or Town, State	\neg
Baltin	permit. Pa Departme Importan any injury		21. Signature Funeral Ser Ice Licensee S. Ware Directo	or St	Name and Address of ate Anatom	y Board	655 W.	Baltimo	ore Street	٦
	nysician Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the disease or condition. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any like limit to immediate the disease or condition resulting in death) Due to or as a consulting to immediate the disease or conditions, if any like limit to immediate the disease or conditions, if any like limit to immediate the disease or conditions are consulting to the disease or conditions are consulting to the disease or conditions that caused the disease or complications that caused the disease or complications that caused the disease or conditions that caused the disease or cause on each line.	eath. Do not ente		uch as cardiac o		est,	Approximate Interval Between Onset and Death	
09/	physician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last c							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown 23c. If yes, outcome of pregnant at 1 ☐ Live Birth 2 ☐ Femant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year	
ls, P.0	uires that to n signed by ald be deta	by	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given i	in Part I.			ribute to the cause of death? 3 Probably 4 Unknow	√n
Division of Vital Records, P.O.	The law req ate has bee page 2 sho	Completed					24a. Was a autop perfor	sy F	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	e f
/ital	sician: certific lirector,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	☐ FR/Outpatier	l au	of Death (Check		ence 6 🗆 Othe	er (Specify)	=
on of \	nding Phy ath. r: After this e funeral c	Certificate: T	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident □ Investigation 28a. Date of injury (Month, Day, Year,	28b. Time of	28c. Injury at work?			ow injury occurre		
Division	al or Atte s after des l Directo d in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (S City or Tow		er or Rural Route Number,	
	e Hospit. 24 hours e Funera	Medical	29a. Certifler (Check (Check only one) 3 Certifying Physician: To the best of my kn	ation and/or invest	tigation, in my opinion, d	death occurred at	the time, date as	nd place, and due	ie to the cause(s) and manner sta	ated.
	To th within	_	29b. Signature and tiple of certifier MD, MHS		29c. License nu	152		09,2	d (Month, Day, Year)	
	,		30. Name and address of person who completed cause of death (I CANOS WELSS 5200 Eastern	tem 23a) (Type, F	Baltimor	re MD	, 212	24-2	734	
	Sta Registr		31. Date filed (Month, Day, Year) 37. Registrar's Sig	gnature da	Nes!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a Pt1,11,25 per me, 896,10/02/09dhb

Reg. No. For A State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Physician 09,2009 Weber Sentember owendolyn /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) University of Maryland Medical

5. Social Security Number (6. Sex **Examiner** Leuter If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Pay, July 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 51 Maryland 218-74-4010 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" any injury or other traumatic excessions. 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21230 1720 Webster Street Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 □ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Robert Hunt Patricia Annette Haggerty ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1720 Webster Street Baltimore, Maryland 21230 Patricia A. Hunt / Mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Glen Haven Cemetery 09/14/2009 Clen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21 Signature of Funeral Service Lice 5311 Edmondson Avenue Baltimore, Maryland 21230 Dan complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas , or com shock, or heart failure. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner WOULC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events PPROVED BY MEDICAL EXAL Examine or Attending Physician; The law requires that the death certificate be executed aftending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Acute Kidney Injury due to Immunosuppression Therapy ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Vivennia nneumould as page 2 : autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 XYes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simcax 22 South

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

OCT 0.2 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day B. Windsor Rober 2009 September 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hopkins Bayview Medical Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 17 9. Birthplace (State or Foreign 5. Social Security Number Maryland 59 Ĩ950 213-54-9157 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1X Yes 2 □ No Elkridge Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21075 USA Washington Blvd #17 6620 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛛 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ollie Dale Alford Wallace Rudolph Windsor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Inez Windsor/Wife 6620 Washington Blvd #17, Elkridge, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/2/2009 Laurel, MD MD National Mem. Pk 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01103 313 Talbott Avenue, Laurel, MD Approximate Interval Between Onset and Death 23a. Part I. Pinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 3d. Date of delivery Month Day Year se contribute to the cause of death? No 3 Probably 4 Unknown 24h Were autopsy findings available

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminar must be notified at

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran attending physician for use as the burial signed by t d be detach After this certifi funeral director,

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic preg Other (speci		2
Part II. Other significant conditions	contributing to death but not resulting in the unc	derlying caus	se given in Part I.	23e. Did tobacco us
				1 □ Yes 2 💆
				24a. Was an autopsy performed? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of Dea	th (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA	Other: 4 Nursing H	lome 5 ☐ Residence 6
27. Manner of Death	28a. Date of Injury 28b. Time of	28c.	Injury at	28d. Describe how injury

			autopsy performed? 1 Yes 2 Mo 1 Yes 2 No		
25. Was case referred to medical		26. Place of Deat	h (Check only one)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)		
27. Manner of Death 1 ▼ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Ti	me of ury 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)		
29a. Certifier 1 Certifying Physics	sician: To the best of my knowledge,	death occurred at the time, date and place	, and due to the cause(s) and manner as stated.		

29a. Certifier										
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated.										
OHE)	and manner stated.									
29h Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000 September 28, 2009 Baltimore, MD 21224

abibian MD

0 2 2009

4940 Eastern Avenue 31. Date filed (Month, Day, 32. Registrar Signa

State Registrar

thours after death.

uneral Director; A

ely filled in by the fu

Within 24 hours are.

To the Funeral Direct

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of	Maryland		rtment of H tificate of L		d Mental Hy	rgiene Reg. No. 🤈 [1119	31635
	Dharatair		1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	Day	Year	3. Time of Death
	Physicia /Medic		Margaret	A. Wagne	r				Octobe			1:00A M
	Examin		4a. Facility Name (If not institution	, give street and num	ber)		4b. City, Town, or			4c. Count		
			Seasons Hos	pice	A (1	- 4 4-1-444	Randa11	If Under 24		Baltimore & Birthplace (Sta		
	Funeral Director		5. Social Security Number 217–18–0420	6. Sex 1 ☐ M X X F	7. Age (In yrs. la 87	Yrs.	Months Days		Nov • 8	, 1921	Ma	nplace (State or Foreign untry) ryland
	ryland Ihow		Usual Residence of Decedent 10a. State 10b. County		1 1	, Town or Lo						10d. Inside City Limits
:	e Ma 3a-f s	Director	MD Bai	ltimore	В	a1tim				45 07	114/1	
3	ii ti or23	Dire	10e. Street and Number				10f. Zip Code	0100	0	10g. Citizen of		
	ath w 5 23a ust t		1007 Hart					2122			·S·A	rican Indian,
9	be filed within 72 hours after death with the Maryland the Hygiene. id other than "natural", or items 23a or 28a-f show event, Im. Madical Exactions or on the notified at	by Funeral	11. Marital Status XXNever Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	ces? k.⊠ No e		Mas Decedent of H f Yes, specify Cuba I □Yes 🏋 No	ispanic Origin an, Mexican, P Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Spec	ack, White	
0000-01717	rould be filed within 72 hours 1 Mental Hygiene. narked other than "natural" natic event, the Medical Ex	Completed b	15. Deceden (Specify only higher	Year or Dat's Education st grade completed)	ites:	(Give	dent's Usual Occup kind of work done o	during most of	f working	16b. Kind of	Business/	Industry
7	within ene. than	d m	Elementary/Secondary (0-12)	College (1-	4or 5+)		cretary	,		Mary1	and	News
3	iled v Hygid ther ant,	ပို	17. Father's Name (First, Middle,	Last)					Name (First, Middl	e, Maiden Surna	ame)	
5	d be ental ked o	To Be		Louis V	Wagner	, Sr.		Ann	a Barba	ra Mou	1ter	
Mai yiaila	shoul nd M marl marl	F	19a, Informant's Name/Relations	-	Vephew		ng Address (Street	and Number	or Rural Route Num	ber, City or Tow	n, State, Z	Zip Code)
5	alth al 27 is r trau		Gerard B. Wag		7	1	Clydes	dale R	d. Way R	eister	stow	n,MD21136
ָנֻ טַ	f Heg		20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date	20c. Location	n - City or	Town, State
2	Pages ent o nt: If I		X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		state i		eemer Ce		0/05/09	Balt	imor	e, MD
Dalimore,	permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, Item 20 ice.	, 1	21. Signature of Funeral Service		,,,,,,	22	2. Name and Addre	ss of Facility		Funer	al Cl	hapel P.A.
			23a. Part 1. Enter the disease, or	complications that ca	aused the death	n. Do not ent	er the mode of dyin	ng, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
	Physician		shock, or heart failure. List Immediate Cause (Final	Athero	scieroni	caro	liorusula	iv dise	45-8			Onset and Death
	/Medical		disease or condition resulting in death)	d	or as a consequ							
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	D =	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						
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0010	icate be executed physician and the burial-transit	dical		d								
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Ö	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		oirth 2 🗆 Feta	death 3	Ectopic pregnand	су			Date of de Month	Day Year
5	the a	/sic	1 □ Yes 2 ☑No 9 □ Unknown	9 ☐ Unkn	nant at time of o own	ieain 51	Other (specify)					
7.	that the de ned by the a detached i	P	Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the u	inderlying cause giv	ven in Part I.	23e. Di	d tobacco use c	ontribute t	to the cause of death?
S,	sign sign d be	d by							10]Yes 2 □ No	3 □ F	Probably 4 Unknown
Ö	w requires t s been signe should be c	Completed							24a, W	as an /24	b. Were a	utopsy findings available
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T T			25. Was case referred to medica					26 Place 6	1 ∐Yes of Death (Check onl		/ re	s 2 No
Division of Vital Records,	Physician: The I r this certificate har ral director, page	Be c	examiner? 1 Yes 2 No	Magnitals	Inpatient 2	EB/Outpatie	nt 3 DOA Oti	2011	sing Home 5 Re		Other (Sp	patient hospite
0	Phys or this oral dii	Ę	27. Manner of Death	28a. Date	of Injury	28b. Time o				e how injury occ		
0	ding th. Afte	ફ	1 ∰Natural 5 ☐ Pendii 2 ☐ Accident invest	ng (<i>Mon</i> i igation	th, Day, Year)	Injury		rk?]Yes 2∐No	0			
<u> </u>	Attending r death. ector: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could	_: 20e. Place	of Injury - At he	ome, farm, st	reet, factory, office		28f. Location	n (Street and Nu Town, State)	ımber or F	Rural Route Number,
5	al or s afte l Dire d in t	Certification: To	4 ☐ Homicide	Duildi	ng, etc. <i>(Speci</i>	7)			Oity of	, 0.0.0)		
1	To the Hospital or Attending Ph within E4 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medica	ing Physician: To the I Examiner: On the b	asis of examina	owledge, dea ation and/or i	th occurred at the investigation, in my	time, date and opinion, death	place, and due to the tone occurred at the tine	he cause(s) and ne, date and pla	d manner : ce, and du	as stated. ue to the cause(s)
U	the I	Medical	one)	and man	ner stated.		29c. Licen					nth, Day, Year)
	5 with 5 00 00 00 00 00 00 00 00 00 00 00 00 00	2	29b. Signature and title of certific	MUEMID:				00574	105			109-
						- 00a) (Tim-	Print)	1			/ ' '	
			30. Name and address of person	Who completed caus	se of death (Iter	St. St	ite 200,	Re ister	rstown, 1	ND. 211	36	
	St	ate	31. Date filed (Month, Day, Year) 32 <u>.</u> F	Registrar's Signa	ature						
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** September 28, 2009 6:30 PM Jeanne Weyforth /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 107 Breakwater Ct. Harford Joppa 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours Min 84 Director 220-12-9789 Jan 29, 1925 Usual Residence of Decedent the Maryland la or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Eventher must by nonce. 21085 United States 107 Breakwater Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: 2 Specify: 3. Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Automotive Sales Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Hoban Mildred Miles 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Weyforth /Son 19846 Gore Mill Road Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Sep 29 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives ekittes 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death) Physician Metastatio 8 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ANo Month Year Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

neral Director: Ai
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) OCT 02 2009

STUASATUAM

DHMH 17 Rev 1/2001

M.D.,

602, 6.

32. Registrar's Signature

casaclans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DA5530

Atwood St, Belair

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State Registrar		State	of Mar	ryland		rtmen <i>tificat</i>				ental Hy	giene Reg. No.	13 13 13 1	j	1637
			1. Decedent's Name	(First, Middle, L	ast)								2. Date of Dea	ath Day	y Year		e of Ďeath
	Physicia /Medica		Julie A	A. White								5	EPTEM			0	5: 34pm
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and the			SAINT			HOSE		st birthday)	If Under			24 Hrs.	8. Date of Birt	th	9 Rin	tholace (Sta	ate or Foreign
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Maryland 21215-0036	nd 2 should lath and Men 27 is marke r traumatic	ř.	19a. Informant's Na					19b. Mailir 5113	g Address	s (Street a	and Numb	er or Rura enue	Route Numb Baltim	er, City o	or Town, State, MD 21	Zip Code) .229	
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, any injury or other traumatic event, once.			osition Cremation 3 5 Dether (Spec		m State	20b. Pla	ace of Dispo metery, cren	sition (Na natory or o	me of other plac	e)	Di	ate	20c. Lo	ocation - City o	Town, Stat	е
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L) #		-: I	27. Manner of Death	n 5 ☐ Pending	28a. Da (M	ite of Injury	y Year)	28b. Time o Injury	f	28c. Injur Worl	y at k?	2	28d. Describe	how inju	ry occurred		
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7_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	1 Certifying	aminer: On the	the best of e basis of anner stat	examinat	vledge, deat ion and/or ir	h occurre vestigatio	d at the ti	me, date a opinion, de	and place, eath occurr	and due to the	e cause(, date an	s) and manner ad place, and d	as stated. ue to the car	use(s)
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	Sta Registra	- 1	31. Date filed (Mont	th, Day, Year) 「	0 10	. negistrai	i s oignat	par	Les !						TEM BO		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 8&14 per family An. Bd. 6896 Topies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day Month Year :34 AM **Physician** 2 2009 /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner toward 13011119 vabie 65 years 1/5/22 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔀 F Trinidad 046-30-8643 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Wadical Evaninar must be notified at 1 ☐ Yes 2 ☑ No Director Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9543 Sea Shadow 21046 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Asian 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🎇 No Indian Specify Specify. will be 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 h (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) education 5+ teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia Biptee Fenwick Chattergoon ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9543 Sea Shadow Columbia, MD 21046 19a. Informant's Name/Relationship (Type. Print) 9543 Sea Shadow Columbia, MD 1 and 2 a Health a Jeff Willey/son 27 permit. Pages 1 and Department of Healt Important: If item 2: any injury or other i injury or other Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∏Donation 5 ☐ Other (Specify) 21. Signature of coneral Survive Licensee 22. Name and Address of Facility
State Anatomy Boaes 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** /Medical Due t (or as a consequence of): **Examiner** Sequentially list conditions Due to or as a consequence of: Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and it be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes Hospital or Attending Physician: 24 hours after death. Euneral Director: After this certifica eately filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death 28d Describe how injury occurred 28c. Injury at 5 Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a
To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Genli

31. Date filed (Month, Day,

OCT

ay, Year)
0 2 2009

Physi		1	Registrar 1. Decedent's Name (First, Midd	fle,Last)		ertificate o			1	2. Date of Dea				3. Time of Death
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(,		1	fa. Facility Name (if not institution 1410 Dalmation Place		number)		4b. City, Belca		Location of Death			c. County of H arford	Death	
Funer			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	_	der 1 Year		8. Date of Bi	rth (MM	VDD/YYYY)	9. Birth Cou	place (State or Foreign
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any	þ	-	15. Decedent's Education (Spe	or Dates:			nt's Usual	I Occupati	on (Give kind of w		16b.	Kind of Bus		
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Ore ges 1 a t of He		- 1	1 Burial 2 Crematio	n 3 Removal	from State	crematory or of			netery,	Date	200.	Location - v	City UI 1	own, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite			4 Donation 5 X Other S	License	state	22	Name and	d Address	of Facility					
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Division of Vittal Records, within 24 hours after the death certificate be executed within 24 hours after death. To the Huspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physician and adjacetor, page 2 should be deathed by the functal by the function of the attending physician and adjacetor, page 2 should be deathed by the function of the death of the attending physician and adjacetor, page 2 should be deathed by the function of the death of the attending physician and adjacetor, page 2 should be deathed to the death of the attending physician and adjacetor, page 2 should be deathed to the death of the attending physician and adjacetor page 2 should be deathed to the death of the attending physician and adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the death of the attending physician and adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 2 should be deathed to the adjacetor page 3 should be deathed to the adjacetor page 3 should be deathed to the adjacetor page 3 should be deathed to the adjacetor page 3 should be deathed to the adjacetor page 3 should be deathed to the adjacetor page 3 should be deathed to the adjacetor page 3 should be deathed to the adjacetor page 4 should be deathed to the adjacetor page 4 should be deathed to the adjacetor page 4 should be deathed to the adjacetor page 4 should be deathed to the adjacetor page 4 should be deathed to the adjacetor page 4 should be deathed to the adjacetor p					2009	2110 hrs			es 2 V No					
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Hospit A hour	S	2	4 Homicide	hysician: To the be			rred at the	e time. dat					-	
Divisior To the Hospital or Attend within 24 hours after death. To the Funcarial Director:	Medical	6		miner: On the basis	of examination a									
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31. Date filed (Month, Day, Year) QCT 0 2 2009 State Registrar

DHMH 17 Rev 1/2001 OCME 2006

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

September 8, 2009

Laron Locke MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of I			giene Reg. No.	3,640
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath	3. Time of Death
	Physicia		Sandria Zimme	ermann				Month	Day Year .ER 29 200	3:30 AM
-	/Medic Examin		4a. Facility Name (If not institution, giv		7)	4b. City, Town, o	or Location of De	ath	4c. County of Dea	h
7			Union Memorial				imore Ci			
	Funeral		5. Social Security Number 6. S	ex 7. A □ M 2 🔀 F	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours M	/Manth De	th 9. Bir	hplace (State or Foreign
	Director		176-42-5122 19 19 19 19 19 19 19 19 19 19 19 19 19	LIW ZZZ.	58 Yrs.			April 1	8, 1951 Nort	in Carollina
			10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary -f sho	φ	Maryland Baltimo	re	Phoe	nix				1 □Yes 2 📉 No
	with the 3a or 28a	Funeral Director	10e. Street and Number 12887 Eagles View	w Road		10f. Zip Code 2113	31		10g. Citizen of What Co	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It.a Modical Exemplar must be notified at ance.	by Funera	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 X If Yes, Give Year or Dates	?]No	Was Decedent of lif Yes, specify Cub	oan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Black, Whit	
ŏ	2 hou atura		15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Business	Industry
215	Jin 72	ple	(Specify only highest gra	ide completed) College (1-4or	life.	kind of work done DO NOT use retire	during most of ved)	vorking		
	d with	Completed	12		Home	Maker			Own Home	
p	e file	Be (17. Father's Name (First, Middle, Last,)			1		, Maiden Surname)	
yla	ould b Ment arkec	은	Leonard Edge				1	yn Willia		
, Maryland	nd 2 sho atth and 27 is m er traum		19a. Informant's Name/Relationship (Albert W. Zimmer)			ng Address <i>(Stree</i> 7 Eagles	tand Number or View RC	Bural Route Numb ad, Phoei	er, City or Town, State, nix, Maryla	nd 21131
J.e.	es 1 a of He of He litem		20a. Method of Disposition	ln	20b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ice)	Date	20c. Location - City or	
Ĭ.	Page Tent ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Hilltop	Service (Corp. 10	/02/2009	Towson, Ma	•
Baltimore,	permit Depart Import any Inj once.		21. Signature of Puneral Service Licer	isee	1	2. Name and Addr 050 York	ess of Facility Road, 1	Ruck Tow Towson, M	son Funeral aryland 21	Home, Inc. 204
			23a. Part 1. Enter the disease, or com	plications that cause	ed the death. Do not en	ter the mode of dy	ing, such as card	diac or respiratory a	arrest,	Approximate Interval Between
, .	Physician		shock, or heart failure. List only Immediate Cause (Final			2 PREST				Onset and Death
	/Medical		disease or condition resulting in death)	, a	s a consequence of):	1 021				20.71n1
	Examiner			b ESC	PHAGEAL	CARCIN	CMA			Syears
	D #	ner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying							6
1180.	ecute ind transi	Examiner	that initiated events	C	acce use					40 years
0,0	e execian a	ŭ	resulting in death) Last	Due to (or a	s a consequence of):					
8760,	cate to shysic the b	dical		d						
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Juneous after death. Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		☐ Ectopic pregnan	cv		23d. Date of de	
O. E.	the at	sici	in the past 12 months? 1 □Yes 2 No 9 □ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of death 5	Other (specify)			Month	Day Year
P.O.	hat th ed by detach		Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause gi	ven in Part I	23e. Did	tobacco use contribute t	o the cause of death?
Division of Vital Records,	quires t n signe	Completed by			Section resulting in the					robably 4 🗌 Unknown
00	sw rec s bee	olete						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
æ	The Ister has age 2	E O							rmed? death?	s 2 🖄 No
ta	Physician: The law this certificate has al director, page 2 a	Be C	25. Was case referred to medical				26. Place of I	Death (Check only		24100
>	nystel iis ce direc	To B	examiner? 1 ∖ ŽiYes 2 ∐ No	Hospital: 1 Inpa	tient 2 ER/Outpatie	nt 3 □ DOA Ot	har		idence 6 Other (Spi	ecify)
0	ng Ph fter th neral	Ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In (Month, D	jury 28b. Time o	of 28c. Inju	ury at ork?	28d. Describe	how injury occurred	
<u>io</u>	endine eath. or: A	atic	2 ☐ Accident investigation	n		M 1 []Yes 2 □ No			
<u> </u>	irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Ir building, e	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (City or To	(Street and Number or F wn, State)	lural Route Number,
	urs al									
	ne Host n 24 ho ne Fune	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Pl 2 ☐ Medical Exam	nysician: To the bes niner: On the basis and manners	of examination and/or in	n occurred at the nvestigation, in my	opinion, death o	ace, and due to the courred at the time	e cause(s) and manner a , date and place, and du	e to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	0			se number		29d. Date signed (Mon	th, Day, Year)
			1	7 .7	D	AT	24380	146	SEPTEM	BER 29, 2019
	\0		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print)				
	10			AHRI	MUSIUN W	NEMORIN	9 E 1-1c	SPITAL	BALTIM	ore mo
	Sta Registr		31. Date filed (Month, Day, Year) OCT 0 2 20	109 2 Regis	trar's Signature	arlas				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month P M 2:45 2009 **Physician** Allen Sept Frances W. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Annapolitan Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🔀 F Sept. 21,1919 New Jersey 89 Yrs. Director 076-18-2740 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Naples FT. Collier Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 34109 4765 Aston Gardens Way, Apt. 301 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Specify: 1 ☐Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) ould be filed within I Mental Hygiene. Elementary/Secondary (0-12) Health Registered Nurse Health and Mental Hygir 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Haines Herman White ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other trauonce. 879 Mallard Circle Arnold, MD 21012 Michael H. Allen / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Atlantic Crematory or other place) 20a. Method of Disposition Sept. 14. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, MD 2009 LLC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home of-Funeral S 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mayon **Physician** disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and physician a sthe burial-1 Physician/Medical attending properties for use as as IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) n signed by the a d be detached for ☐Yes 2DNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performe has 2 ZIVO 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Adate Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide

law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

death with the Maryland

filed within 72 hours after

1 and 2 should

Baltimore, Maryland 21215-0036

4 Homicide

29a. Certifier

Medical

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 9055 Cheviolet Dr. Sut 103, Elliost Cl

2009

Year) 31. Date filed (Month,

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Virginia Browning September 26 2009 06:41 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Water St. Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 💢 F Months Days Hours Feb. 2 1923 Maryland 214-14-6849 86 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1XYes 2∐No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 44 Water Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dispatcher City Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Evans Maude Naomi Foltz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

44 Water Street Hagerstown Maryland 21740

ONO

stown

21740

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be rediffed at once. Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

Director

Funeral

Completed by

Be

ည

<u>Anderson / Daughter</u>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

324 E. Antictam

31. Date filed (Month, Day, Year)

Physician

Examiner

Funeral

Director

/Medical

Physician /Medical Examiner

burial-trar attending physician for use as the buria within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	cemetery, cremato	ry or other place)	Date 200. Lt	ocation - City or I	own, State					
	4 □ Donation 5 □ Other (Specify)		em Crematory 9/	28/2009 Free	derick,	Marylan	.đ				
	21. Sign of Funer I Service icense	22. N	ame and Address of Facility Re	st Haven Fu	neral Ch	apel					
	2 6.12	160	1 Pennsylvania	Ave. Hagers	town Mar	yland 2	1742				
	23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do not enter to	ne mode of dying, such as cardiac	c or respiratory arrest,		Approximate Interval Betwo Onset and De	een eath				
	Immediate Cause (Final disease or condition	schemic Can	diomyopath	W		years					
	resulting in death) Due to	(or as a consequence of):		(
	Sequentially list conditions b.										
D	Sequentially list conditions, if any leading to many cause. Enter Underlying Cause (Disease or injury	stry leading to him solute Die to (or selections of):									
9	that initiated events c.	c									
נֿ	Due to	(or as a consequence of):									
2	d										
y Sicial Williams	in the past 12 months?	nant at time of death 5 0	otopic pregnancy her (specify)		23d. Date of deli Month	,	ear				
	Part II. Other significant conditions contributing to de	eath but not resulting in the unde	lying cause given in Part I.	23e. Did tobacco u	use contribute to	the cause of de	ath?				
2	Type 2 Diabetes Me	ellitus Itu	pertensión	1 □ Yes 2	No 3□ Pro	obably 4 ☐ Ur	nknown				
	Congression Heart	E.O.		04	T 845 W						
1	Congestive react	1 aux wa		24a. Was an autopsy performed?	prior to c	topsy findings av completion of car	vallable use of				
5	Chronic Renal Insu	Glicency Per	ipheral Vascula	1 □ Yes 2 No		2 🗆 No					
3	25. Was case referred to medical examiner?	(2)	26. Place of Dea	ath (Check only one)							
2		Inpatient 2 ER/Outpatient		lome 5 Residence		cify)					
ation	2 Accident investigation	th, Day, Year) Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injur	y occurred						
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of Injury - At home, farm, street, ing, etc. (Specify)	factory, office	28f. Location (Street an City or Town, State	id Number or Ru	ral Route Numb	er,				
ancai -		e best of my knowledge, death or pasis of examination and/or investing the stated.	curred at the time, date and place digation, in my opinion, death occu	e, and due to the cause(s urred at the time, date and	and manner as d place, and due	stated. to the cause(s)					
É	29b. Signature and title of certifier		29c. License number	29d. Da	te signed (Month	n, Day, Year)					
	1 / () t 3 (2)	MD CM	018830	Sept	ember 2	28,200	9				

DHMH 17 Rev 1/2001

DIC

State Registrar 203

Amended #5, 09/28/09, nls, per fd, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death		giene	9 91643
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath Day Year	3. Time of Death
	Physici /Medic		William Mack Bowers	09	18 200	9 1120 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cumber I and		4c. County of De	
	Funeral		5. Secret Secretic Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bird	h 9.8	irthplace (State or Foreign
	Director		- 226-22-5725 1M2 M 2 □ F 82 Yrs. Morths Days Hours Will.	(Month, Da June		aryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary a-f sh	tor	Maryland Allegany Frostburg			1 X Yes 2 □ No
	th the	Director	10e. Street and Number 226 Armstrong Avenue 10f. Zip Code		10g. Citizen of What (Country?
	ath w		21532-		U.S.A.	
	Items Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 M Married 1 □ Never Married 2 N Married	ecify Yes or No Rican, etc.)	14. Race - An Black, Wh	
036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by	1 □ Never Married 2 M Married 1 M Yes 2 □ No If Yes, Give 1 □ Yes 2 M No Specify: Year or Dates: Www. III □ Yes 2 M No Specify:		Specify:	hite
5-0	72 ho 'natur	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired)	ing . I	16b. Kind of Busines	
121	within iene, than "	Jup	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Research Technician		Ballistics Lab	oratory
d 2	filed Hygi other ent, the	Be Co	-	e (First, Middle,	Maiden Surname)	
/lan	2 should be and Mental is marked c	To B	Graham S. Bowers Sarah Wine	ebrenner		
Maryland 21215-0036	2 should n and Men is marke raumatic		19a. Informant's Name/Relationship (Type. Print) Dolores Bowers wife 19b. Mailing Address (Street and Number or Run 226 Armstrong Avenue Fros			
e, l	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be refilled at		220 1 21 22 22 22 22 22 22 22 22 22 22 22 2	tburg Date	MD 20c. Location - City of	21532-
nor	ages ent of it; If it y or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	er 21, 2009	Frostburg	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important; If Item 2 any Injury or other	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	21, 2005	riosionig	iviai ylailu
<u>~</u>	8 9 E 8 8		John R. Alert Durst Funeral Home, 57 H	Frost Ave.,	Frostburg, MD	21532
		33 - 23	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. methostetic cancer resulting in death)			4 105
	Examiner		Due to (or as a consequence of):			
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): c			
	and transi	Examiner				
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687	tificate ig phy as the	ledical	d			
Вох	e law requires that the death certifi has been signed by the attending le 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	,
P.0.	he dea the a	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		Month	Day Year
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rds	quires an sign	ed by		1 🗆 Y	′es 2 □ No 3 □	Probably 4 Unknown
Division of Vital Records,	law re as be 2 sho	Completed		24a. Was	an 24b. Were	autopsy findings available o completion of cause of
<u>د</u>	: The cate h	Com		perfo	rmed? death?	
Ĕ	sician	Be	25. Was case referred to medical examiner? 1 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2 Types 2			
ō	tending Physician: The leath, tor: After this certificate hithe funeral director, page	다 나	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (Sp now injury occurred	pecify)
io	ath, or: Aft	atio	1 ☑Natural 5 ☐ Pending (Month, Day, Year) Injury Work?" 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
<u> </u>	or Atten after deatl Director: In by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (8 City or Tox	Street and Number or i	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(s) and manner	as stated
	To the Hospital within 24 hours a To the Funeral completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time,	date and place, and d	ue to the cause(s)
	To the within to the comp	≥	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
	9+		mD03676	20	reptents (9,2009
	MAI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIKramaditya Poonai mo 924 Seton Drive Cu 31. Date filed (Month, Day, Year) 32. Benistrar's Signature (mberio	and, mo	21502
	Stat Registra	е	31. Date filed (Month, Day, Year) SEP 21 2009 Seven S. Aganture			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 15, 2009 1:50 Myrtle Marie Barrett 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 X 87 Missouri 490-12-4454 Feb 5. 1922 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No MD Calvert Chesapeake Beach 10g. Citizen of What Country? 10e. Street and Number USA 20732 7403 B 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Company Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fannie Goss Newell David 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1928 St Clair Brentwood, MO 63144 Cathy Cline (great niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2009 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Sep 21 Lee Crematory Clinton, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd Owings, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Azute Myocardial 24 40 disease or condition resulting in death) Due to (or as a consequence of): Arterio clerotre Carreto vascular Disease years coronary artem Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Physician /Medical **Examiner**

Examine

permit. Pages Department of Important: If it any injury or o once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-transit as

and

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire

Division or Vital Records, P.O. Box 68760,

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dical	•	d								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	23d. Date of delivery Month Day Year							
þ	Part II. Other significant conditions co Acute pulmonary ede	co use contribute to the cause of death?								
Completed	Acute Respiratory / Cereprovacion I	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No								
9	25. Was case referred to medical	26. Place of Death (Check only one)								
.o B	examiner? 1 □ Yes 2 No	Hospital: Inpatient 2	nce 6 Other (Specify)							
tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred				
Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, street, fac y)	etory, office	28f. Location (Str City or Town	eet and Number or Rural Route Number, State)				
Medical C	29a. Certifier Description 29a. Certifying Physics (Check only one) 2 Medical Example 19a. Certifying Physics (Check only one)	/sician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, death occur tion and/or investiga	red at the time, date and plac tion, in my opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner as stated. ate and place, and due to the cause(s)				
Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month, Day, Year)				

P. Sterner

D17245

Owings, MD

29d. Date signed (Month, Day, Year) September 15, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19 Chesapeake Beach Road Gerald Sterner, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State SEP 21 2009 Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 36 Dernard eptember 13,2000 /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NONE **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 7, 9. Birthplace (State or Foreign Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 X M 2 □ F 79 1930 **NÉW YORK** 132-22-9764 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c City Town or Location show ms 23a or 28a-f sho must be notified at 1 Yes 2X No Director ANNE ARUNDEL ANNAPOLIS MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code UNITED STATES items 23a 803 COXSWAIN WAY, UNIT 103 21401 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No 1951—
If Yes, Give
Year or Dates: 195 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ortant: If item 27 is marked other than "natural", or iter injury or other traumatic event, the Medical Examiner. 1 Never Married 2 X Married 1 Yes 2X No Specify: WHITE 20 3 Widowed 4 Divorced 1953 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) INTERNAL REVENUE Elementary/Secondary (0-12) College (1-4 or 5+) REVENUE OFFICER SERVICE other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JACOB BECKER BETTY LEIBERMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and Nis ma 19a. Informant's Name/Relationship (Type. Print) 21401 Department of Health a Important: If item 27 is any injury or other tratonce. MALVINA PERLMAN BECKER/WIFE 803 COXSWAIN WAY, UNIT 103, ANNAPOLIS, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE OF VETERANS | SEPTEMBER 15 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 4 Donation 5 Other (Specify) CEMETERY 21. Signature of Funeral Service Licenses M00672 Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line tamponade Immediate Cause (Final 2 fac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) at **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tens TOP physician and is the burial-tran Due to (or as a consequence of): P Physician/Medical ‡ as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the at ld be detached for 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably Unknown 1 T Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 2 □ No 1 ☐ Yes 2 🗷 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No 1 Inpatient ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide

The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, Hospital or Attending Physician: Director: A within 24 hours aft

To the Funeral Dir

completely filled in

filed within 72 hours after

21215-0036

3altimore, Maryland

Pages 1 and 2 should

10+1

Registrar

Medical

Peter 31. Date filed (Month, Day, Year) State

29a. Certifier

(check only one

29b. Signature and title of eartifier

32. Registrar's Signature

and manner stated.

and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

09

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

845-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13 Day 2009 Year Month 7:32P M Sep. Physician Brodie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville The Casey House 8. Date of Birth (Month, Day) Dec. 3 9. Birthplace (State or Foreign f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. England Days Hours 1919 1 □ M 2 💢 F Dec. 89 Yrs. 213-54-7338 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Michael Examiner must be notified at 1 ☐Yes 2 ☐ No Chevy Chase Directo MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 20815 8100 Connecticut Ave. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 ∏ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie "Unknown" Joseph Black ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is in any Injury or other traum once. 7001 Buxton Terrace Bethesda, Maryland 20817 Stephan Brodie, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3X Removal from State |Falls Church, Virginia King David Mem. Grds 9/17/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Banzansky-Goldberg Memorial Chapel 21. Signature of Funeral Service Licensee 1170 Rockville Pike, Rockville, MD 20852 23a. 251. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Critical Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) detached 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Peripheal Vascular Disease 24a. Was an certificate has autopsy performed? Yes 2 No or Attending Physician: The 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical director Be examiner? Other: 4 Nursing Home 5 Residence 6 2 Other (Specify) Hospital: 1∐Yes 2X∏No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 X Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
 To the Funeral Director: Aft completely filled in by the fun 1 ∐Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier J. Koueltchou, 163748 September 15, 2009 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou 201 East University Parkway, Baltimore, Maryland 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parke 21

DHMH 17 Rev 1/2001

Registrar

09-07474 Sheila Beall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nena Dean		For State	Cert	tificate of	Death			,,,	R	eg. No.		01	0 01	61
Physician/	<u>Re</u>	gistrar Decedent's Name (First, Middle,Last)						2.	Date of Dea Month	th Day	Year	~ S	3. Time of Death	0 7
Medical Examine		Sheila E.	Beall						Month Septembe	er 24, 2	County of	Death	11101110	—
	48	a. Facility Name (if not institution, give s 3708 Leverton Street	treet and number)		4b. City, Tov Silver S		cation of			М	lontgom	ery		
Funeral Director	1	Social Security Number 6. Sex 531-32-8801	7. Age (In yrs. Ia		If Under Months	1 Year Days	If Under		8. Date of Bi			Foreign	place (State or htry) Canada	a
Director		sual Residence of Decedent	1 2XF 74	Yrs										
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21215-0036 sold be filed within 7 Mental Hygiene. marked other than c event, the Melica		7. Father's Name (First, Middle, Last) Evelyn Nigel Dodg	e				Sh	neila	a Gran	t Fr	aser			
tould be d Ments is mark tic even	- 1	9a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address	(Street	and Num	ber or Ru	ral Route N	umber, C	ity or Tow	n, State	, Zip Code)	
MD 1d 2 sho alth and m 27 is raumati		Josephine B. Evan	s/ Daughter	2320	Kaywo	od	Lane	, Si	Lver S	prin	lg, M	City or	Town, State	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once TO Be Completed by Finneral Director	1	21. Signature of Funeral Service Licens	c. MO1117	27	eVol 1	une Ga	ral 1	Home rsbu	, 10 E	208 208	Deer 377	Par	k Drive,	
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vision Attender de pirecte in by 1	<u>일</u>	2 Accident Investigat 3 Suicide 6 Could not	be 28e. Place of Injury - At	home, farm, s	treet, factor	y, office	building, e	etc.		on (Stree vn, State		iber or F	Rural Route Numb	er, City
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	edical (29a. Certifier 1 Certifying Physic (Check only one) 2 ✓ Medical Examine	ian: To the best of my knowler:On the basis of examination	edge, death oo n and/or invest	curred at thi igation, in m	e time, c y opinio	ate and p n, death o	occurred	at the time, o	date and	place, and	due to	the cause(s)	
Total	Medi	29b. Signature and title of certifier	and manner stated.				se numbe			29	d. Date si	gned (N	fonth, Day, Year)	
DTIPEND		Commed 11	ADDALIA			0.0	.M.E.			s	eptemb	er 25,	2009	
		30. Name and address of person who	completed cause of death (It	em 23a)										
		Carol Allan, MD Assista	ant Medical Examiner	111 Per	n Street,	Baltin	nore, M	2120)1					_
	ate	31. Date filed SEP ^{Da} 2 ^Y 9 ^{r)} 20	37 Registrar's Sign	ature As a	west.									
Regist	rair													

VOID

CERTIFICATE

2009-31648

SEE

CERTIFICATE #

2009 - 30857

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09/19/2009 **Physician** 9:30 P M James Carl Benvenuto /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Atlantic General Hospital Berlin Worcester If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral X**□ M 2□ F Months Days Hours Min. 98 082-05-8342 20, 1911 New Jersey **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Worcester Ocean City 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ŭ.S.A. 12930 Center Dr. 21842 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1)XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Codlege (1-4or 5+) Machinist Manufacturing s 1 and 2 should be filed w if Health and Mental Hygier Item 27 is marked other th other traumatic event, Ith 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Domenic Benvenuto Matilda Santora ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 12930 Center Dr. Ocean City, MD 21842 Frank Benvenuto Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park |9/22/09 Berlin, Maryland of Funeral Service Licensee 22. Name and Address of Facility 108 William St. The Burbage Funeral Home Berlin, MD 21811 Approximate Interval Between Onset and Death e dise y e, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest t failur. List only one cause on each line. shock, or he Immediate Cause (Final **Physician** lostridiu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate nas been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Fibrillation 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Record Completed obstructive Polmonary disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 XNo 1 ☐ Yes 2 No 1 ☐ Yes of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Amelano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Healthway Szymalano Atlantic General Hospital Berlin MD, 21811 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G896 to Waryland Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:00 AM September 22, 2009 Mildred Smith Bowen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton Homestead Manor If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□M 2\ F Yrs. 1921 Maryland 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 ☐ No Denton Maryland Caroline Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21629 1021 S. Heritage Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Worker Federal Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Jane Ward Henry Woodfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 798, Greensboro, Maryland Emily Gray/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Eastern Shore Veterans Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Sept. 29, 2009 Hurlock, Maryland 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home 21. Signature of Furieral Service Licensee 106 W. Sunset Ave., Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Examiner To Be Completed by Physician/Medical Certification:

Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. attending physician for use as the buria been signe should be after death.

Director: After this certific in by the funeral director, within 24 hours a

Funeral

Director

of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Medical Evertime must be notified at

permit. Pages 1
Department of H
Important: If its
any injury or ot

Physician /Medical

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

the Maryland

Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	nentic		
	Due to (or as a consequence or).			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as a consequence of):			
that initiated events resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions cor	tributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
			24a. Was an autopsy performed?	
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 ER/Outpatient		ath (Check only one)	a Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 ☐ Certifying Physical Control (Check only one)	ician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place restigation, in my opinion, death occu	e, and due to the cause(urred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	(M)	29c. License number D005335		ate signed (Month, Day, Year)
30. Name and address of person who co	impleted cause of death (Item 23a) (Type, 13c, Lednum	Print) Ave Prest		
31. Date filed (Month, Day, Year)	32. Registrar's Signature			

DHMH 17 Rev 1/2001

State Registra Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	arylan		rtment o			Mental Hy	giene Reg. No.	2009	31651
п	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of De Month	ath Day	Year	3. Time of Death
4	/Medi			ler						Septemb		2009	1700 M
	Examir	ner	4a. Facility Name (If not institution, gir	ve street and number)	An/	MALL	4b. City, Tow	n, or Local	SOUNT		4c. C	County of Death	
	Funeral Director		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. l	ast birthday) Yrs.	If Under 1 Ye Months Da	ear If Ui	nder 24 Ars. urs Min.	8. Date of Bir (Month, Da Feb 20	ay, Year)	Cou	place (State or Foreign intry) yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation						10d. Inside City Limits
	Mary Ind	tor	Florida Pasco)	Zeph	nyrhill	s						1 □ Yes 2 No
	or 28s	Direc	10e. Street and Number		1 1		10f. Zip Coo	de			-	en of What Cou	intry?
	ath wi	ral	37811 Chancey Ro				3354					S.A.	
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show offert Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1			√as Decedent Yes, specify (□Yes 2 X		c Origin? (S xican, Puert ecify:	pecify Yes or No o Rican, etc.)		 Race - Ameri Black, White, Specify: 	
2-0	72 hou natura	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give I	ent's Usual Oci and of work do	one durina	most of wor	kina	16b. Kind	d of Business/fr	ndustry
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	'life. L teac	O NOT use re	etired)		5	Carc		ystem ounty Schoo
	filed withii Hygiene. other than ent, it e Iv	Be Co	17. Father's Name (First, Middle, Las.			Leac	iier	18. N	nother's Nan	ne (First, Middle			Juliey School
Maryland	should be filed and Mental Hygis s marked other umatic event, II	To B	Harry E. Holsinge	er					Gertru	de Rowl	.and		
lar	S S S	ľ	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (St	reet and N	umber or Ru	ral Route Numb	er, City or	Town, State, Zi	ip Code)
	is 1 and 2 of Health item 27 i		Lee Butler/ son 20a. Method of Disposition		Joh B				hool F	Road; La		DE 19	9956
nor			1 X Burial 2 ☐ Cremation 3 [lace of Disposemetery, crem			00./2			•	
Baltimore,	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Furreral Service Lice		Gre	22	Name and A	ddress of F	acility	ein Fur oro, MI			Maryland PA
			23a. Part 1. Enter the disease, or con	nplications that cluser	the death								Approximate
- 01	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		resul		CVY	7 he	mon	ge			Interval Between Onset and Death
	Examiner			HTN	a consequ	derice or).							
	₽ ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Que to (or ea	a nonsequ	enes of):							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hother	2.0000000	iongo off:							
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687	ifficate g phys	edic		d. 03100	10.0	-							W
O. Box	The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal	Ideath 3	Ectopic pregr Other <i>(specif</i>				23	3d. Date of deli Month	very Day Y ear
σ.	that the de ned by the		Part II. Other significant conditions	contributing to death b	out not resu	ulting in the un	derlying cause	e given in f	Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
Records,	w requires been sign should be	ed by								1 🗆	Yes 2□] No∈ 3 □ Pro	obably 4 🕅 Unknown
eco	e law re has ber e 2 sho	Completed								24a. Was		24b. Were aut	topsy findings available completion of cause of
E B		Con								perfe 1 □Yes	ormed?	death?	2 □No
Vital	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Other:		th (Check only			
of	Physer this eral di	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatien 28b. Time of		41	_ Nursing ⊢	ome 5 ☐ Res 28d. Describe			cify)
ion	Attending Ph ir death. ector; After thi by the funeral i	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay, Year)	Injury		Injury at Work? 1 □Yes	2 🗌 No		, , ,		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		ury - At ho c. <i>(Specif</i>)	ome, farm, stre	eet, factory, off	ice		28f. Location City or To	(Street and wn, State)	Number or Ru	ral Route Number,
	e Hospi 24 hour e Funer	Medical	29a. Certifier 1 (Check only one) 1 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurred at t restigation, in	he time, da my opinior	ate and place n, death occu	e, and due to the erred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	/			29c. Lie	cense num	ber		29d. Date	signed (Month	i, Day, Year)
			MAMAL	M	13.			006	773	8	9/2	14/00	7
			30. Name and address of person who						9 41		- 1		
	Sta	ate.	ALI SABERI 100 31. Date filed (Month, Day, Year)	E. CARROLL 32. Registi			ury, M.	0,21	801				
	Reaist		SFP 2 5 2009			South							

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMENDED #6 PER FH 9/24/09 Certificate of Death CCHD AS 2. Date of Death 3. Time of Death Physician/ 0430 September 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ist Ea 1a) Hospita Memoria If Unde If Under 24 Hrs 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In) **Funeral** -18-3633 1 🗆 M 2 👿 F Months Days Hours Min. Country) Director Usual Residence of Decedent Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 □ No aroline 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black White etc. 1 Never Married 2 Married Yes 2 No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Mental Hygiene. Seconday (0-12) College (1-4 or 5+) machine Bradler Be ပ Health and N Number or Rural Route Number, City or Town, State, Zid Code) 19a. Informant's Name/Relationship (Tva 19h. Mailing Address (Street and oura 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō cemeter crematory ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ non Medical resulting in death) a consequence of Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 🗆 No 1 Tyes Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ပ 1 TYes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death. 1 Tes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) 2009 65656

Registrar DHMH 17 Rev 7/2009

State

M. 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 3:10PM September 19, 2009 Harry Melvin Burris 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline Marydel 27179 Temple Rd. 8. Date of Birth (Month, Day,) Jan. 14, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Social Security Number 6. Sex 1 M 2 □ F Year) 942 Months Days Hours Min. Maryland Jan. 215-38-1638 67 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🛛 No Maryland | Caroline Marydel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21649 27179 Temple Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Ye ar or Dates: Specify. Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Mechanic 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susie Pearl Seward Arthur Burris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27179 Temple Rd., Marydel, Maryland Christine M. Burris/Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State Sept.23,2009 Greensboro, Maryland Greensboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home
106 W. Sunset Ave., Greensboro, Maryland 21. Signature of Foneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on the control of the death. Shock, or heart failure. List only one cause on the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con Immediate Cause (Final disease or condition resulting in death) Due to (or as / consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, it all volice Exs. nit or must be a cultival at

Il Hygiene.

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permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

within 72 hours after death

Baltimore, Maryland 21215-0036

and attending physician and for use as the burial-tran signed by t t be detach cate has b page 2 si director,

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certificate |

After this funeral

within 24 hours atter usas...

To the Funeral Director: Af

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician/Medical þ Completed

Examine Be Certification: To

Medical

29a. Certifier

(Check only one)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

28c. Injury at Work?

autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home - 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 000 1 ☐ Yes

3 Probably 4 Unknown

23e. Did tobacco use contribute to the cause of death?

1 🗌 Yes

24a. Was an

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of contifier

130051786

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chestertown Ferguson Andrew 120 Speek 31. Date filed (Month, Day, Year) Registrar's Signa

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /		rtment of He			27.27	275		in the S
ling.			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of L	veatri ——–	2. Date of Deat	eg. No.	110	3. Time of	Death
	Physici /Medi		Joseph Biggs Bryson	ı. Jr			Septemb	er 27.	Year 2009	1250	РМ
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. Count			
AC.	5		Calvert Manor Health Care Center		Rising				cil		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 17-14-0453 1. Sex 1. M 2 □ F 88	Yrs.	if Under 1 Year Months Days		NOV 9,	1 ^y 6 ^a 20	_ Coun	ace (State of try) aware	r Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Loc	ation				11	0d. inside Cit	y Limits
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	with the Maryland a or 28a-f show t be notified at	Sirec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of	What Coun	try?	
1	ath w	<u>a</u>	101 Washington Avenue		21921				ed Sta		
/ 98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? World 1 ☒ Yes 2 □ No. If Yes, Give War II	- 1	/as Decedent of His Yes, specify Cubar □ Yes 2∑ No	spanic Origin? n, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)		ce - America ck, White, of fy: Whi	etc.	
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	To the within To the Comp	Me	29b. Signature and five of certifier	v	29c. License	number	6019	9d. Date sign	ed (Month,	ay, Year)	
	100		30 Name and address of person who completed cause of death (Item 23a	a) (Type, P	rint)	70	7771	0[7/1	-/-	
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	Sta Registi		31. Date filed (Month, Day, Year) OCT 0 2 2009 32 Registrar's Signature	pa	Kel						

29a. Certifier (Check only one)

To Be Completed by Funeral Director

Physician /Medical

Examiner

Funeral

Director

State Registrar				C	ertifica	te of	Death		R	eg. No.		1.55
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Was case refer	red to medical						26. Place	of Death	1 □Yes	· -	1 □ Yes	> < 1140
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3 ☐ Suicide	6 ☐ Could not be	28e. Place of I building,	mirror At to a			.10		_	oof Leasting (O		(Alumbayor D	ural Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical

Examine

Be Completed by Physician/Medical

Medical Certification: To

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARESTOWN, MD 1126 OPA 32. Registrar's signature

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 13 Norman Cator 2009 9:33 P^{M} 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/31/1940 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 68 Months Days Hours Min. 215 38 2933 1 XM 2 ☐ F MaryTand Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Montgomery Washington Grove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17050 Railroad St 20880 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Master Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Cator Katherine McGaha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine B. Pearre (sister) 6105 Toyota Drive/Jacksonville FL 32244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ٌ Cremation 3 ☐ Removal from State Metropolitan Crematory 9/17/09 4 ☐ Donation 5 ☐ Other (Specify) Alexandria VA 22. Name and Address of Facility 21. Signature of Funteral Service Licensee Warmawa Cremation Services and Annapolis MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatocellular Carcinoma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Acute Renal Failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 ANo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

10a. State

VA

Examiner

Funeral

Director

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Directo

Funeral

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Completed

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attending physician and for use as the burial-tran been signed by the should be detached

9/13/09 9:33.PM

ATOR , NORMAN

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed by After this certificate has been funeral director, page 2 should Be Certification: To

IF FEMALE: 27. Manner of Death 1 ☐ Natural

neral Director; A

To the Hospital or All within 24 hours after c

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year)

D22775

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 9/14/09

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5454 Wisconsin Ave/ Chevy Chase MD 20815 Frederick G. Barr MD

an mo

31. Date filed (Month, Day, Year)

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

5 Pending investigation

6 Could not be

determined

32. Registrar's Signature

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 19a, b per fh g896 10-13-09 vt State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Physician 12:30 p^M September 19, 2009 Jimmie Collins /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Lorien Nursing Home Columbia Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/17/1947 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Days Hours 1**⊠**M 2□ F Kentucky Director <u>227-68-98</u>06 62 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Elkridge MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21075 5960 Elk Forest Court or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 1969-If Yes, Give Year or Dates: 1973 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 7 Is marked other than "natural", or iten traumatic event, the Medical Examiner 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) es 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) NSA Oral Historian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ula Brown Carl J. Collins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5960 Elk Forest Court Elkridge, Md. 21075 Claudia C. Collins / wife permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 09/23/2009 | Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Si mature of Funeral S nucle Licensee M00845 1 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) anuric days **Physician** /Medical Due to (or as a consequence of): Examiner ongest - rue Succeptibility list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ovas a consequence of): ste Drain burial-transi and Due to (or as a consequence of): P.O. Box 68760, physician pe Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? performe methicillinresistant 2□ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2♥ No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After t Hospital or Attending 1 Natural
Accident 5 ☐ Pending investigation the Funeral Director Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (item 23a) (Type, Print Columbia 633 Year) 21 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	Physicia /Medic Examin	al
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C	irector	
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1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 18, Year 2009 11:50 a ^M Ethel G. Chaillou 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ellicott City Howard Ellicott City Nursing & Rehab. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Hours Days 1 □ M 2 🖫 F 215-12-9993 86 12/03/1922 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director Howard West Friendship 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21794 3442 Rosemary Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Warfield William Gohlke ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wallace E. Chaillou - son P.O. Box 350 West Friendship, MD21794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State 09/22/2009 Baltimore, MD Loudon Park Cem. 4 Donation 5 Dother (Specify) 21. Signature of Fymeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy pertormed death? 2□No 2X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ျှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Fo the Funeral 29a. Certifier 1 TXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 D30641 September 19, 2009 me 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi 201-109 Back River Neck Road Baltimore, MD 21221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **SEP 21** parker Registrar

DHMH 17 Rev 1/2001

State of Mary	land / Depar	rtment of Hea	Ith and Me	ntal Hygien

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, Jeanette Todd Cephas 1:00 A Sept. 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Dorchester Chesapeake Woods Nursing Home Cambridge 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day July 25, 1931 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🗑 F 78 Yrs. Maryland 214-28-3143 Director Usual Residence of Decedent with the Maryland 10d. fnside City Limits 10a. State 10b County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Federalsburg 1 Yes 2 No MDCaroline Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21632 4810 Webster Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Mcdcal Ferral RDRB. Black, White, etc. ☐Yes 2☐XNo 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Specify: 35 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sally Coleman Banus Todd ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4810 Webster St., Federalsburg, MD 21632 Joan Bataille/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Removal from State Eastern Sh. Veterans 09/25/09 Hurlock, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Muhael askew 216 N. Main St. Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arterioserente Cordiovolade ditele Immediate Cause (Final disease or condition resulting in death) Physician ce of): desphage will malner protein /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit The law requires that the death certificate be executed physician ar s the burial-ti Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 Ko 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 2 - No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Pface of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 4 Narsing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 Tes 2 No death. investigation 2 Accident within 24 hours after deatl
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 503 CATBRIDGE 31. Date filed (Month, Dat F gistrar's Signature 32. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indeliber 1677 4 Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 5 Registrar TCHD, 09/15/09 pha 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** SEPTEMBER 2009 GLADYS MAY DYOTT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON TALBOT WILLIAM HILL MANOR Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min 1 M 2 K F 07/05/1920 DELAWARE 89 Director 213-16-7043 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner resust be neithed at 1 ☐ Yes 2 No Director MD TALBOT EASTON the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ٨ith USA 21601 640 MECKLENBURG AVENUE death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐Yes 2 M No IfYes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 □ Never Married 2 □ Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2**X**No Specify Specify: <u></u> 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 0 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SUSIE CLARK JOHN McAULIF SULLIVAN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27960 HOLLY ROAD, EASTON, MD 21601 PATRICIA WOOTERS/DAUGHTER Department of Health Important: If item 27 any Injury or other troone. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State E.S. MD VETERANS CEM. 09/16/2009 4 ☐ Donation 5 ☐ Other (Specify) HURLOCK, MD 21. Signature of Funeral Service Licensee FELLOWS, drengt Fenbein & Newnam Funeral Home, P.A. Joseph Ostrowski per DVR 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) coul **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. ģ 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Ves 2 No 1 ☐Yes 25. Was case ref_rred t examiner? 26. Place of Death (Check only one) Be Other: Hospital: this c 4 ☑ Nursing Home 3 ☐ Residence 6 ☐ Other (Specify) 2 🖬 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To 27. Manuar of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director:
d in by the f 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours aft the Funeral Di mpletely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 7 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certifier è Pha DUTCHMAN'S LANE EASTON 501 Wood 31. Date filed (Mon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DENNISON **Physician** /Medical 4c. Apunty of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Date of Birth (Month, Day, Z-Z-9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□ M 2**X**F Months Davs **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience in ast be nothed at 1 Yes 2 No BEDFORD HUNDMAN Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 15545 294 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3

Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental H Be WEINBROCK MIDDLETON HANNAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2: ment of Health a ant: If item 27 is HYNDMAN PA PO William Dennison Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or c 1 → Burial 2 □ Cremation 3 → Removal from State HUNDMAN 9-10-09 HYNDMAN 4 ☐ Donation 5 ☐ Other (Specify) 169 Clarence ST 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Harvey H. Zeigler F.H. Inc HYNDMAN PA 15545 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Loi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 21 No 2 🗷 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 🛮 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 904 Seton DRIVE SUITE 203 Chumberland, MD 21502 R. Qamar Zaman

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 10 2009 5:29A M **Physician** Phyllis A. Davis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Center Cheverly 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 47 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. Maryland 1 □ M 2 F 217-52-1713 61 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdral Evaminer must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐Yes 2X No MarylandPrince George's Capital Heights Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5821 Sherriff Rd. 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Data Transcriber Commerce 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James A. Anderson Sr Evelyn Griffin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5821 Sherriff Rd. Capital Heights, Md.20743 Willie L. Davis (Husband) 20c. Location - City or Town, State 20b. His ce of Disposition (Name of Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial 9-16-09 Gardens Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Windows of &cilicons Mortuary, P.A. 21. Signature of Funeral Service Licenses eese MOUH82 14 821 West St. Annapolis, Md. 21401 arry Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** months Cancer Pancreas, Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð Pulmonary Emboli Recurrent 1 ☐ Yes 2 🖫 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 KER/Outpatient 3 □ DOA 1 Yes 2 No 1 🗌 Inpatient Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Peath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation after death.

Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours aft To the Funeral Di completely filled in

(Check one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertific 29c. License number 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS MAISER WM 30A AP NAM SRO TESORI 2100 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 1

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physicia /Medic Examin

1 - For State

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Medical Examinat must be retified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

102 Registrar

	- Hegistiai											
1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 13,										2009	3. Time of Death 9:00 P M	
al			give street and number)		4b. City, Town, o	r Location of	f Death		4c. Cour	nty of Deat	h
er			General Ho		1	Cheverly				Prin	ce Ge	orge's
-	5. Social Security N			ge (In yrs. la		If Under 1 Year	If Under 2	24 Hrs. 8. [ate of Birth		9. Birt	hplace (State or Foreign
	577-52-5	5877	1 □ M 2 X F	71	Yrs.	Months Days	Hours	Min. (Month, Day, Y	^(ear) 1937		ington, D.C.
	Usual Residence of							110	137			,,,
	10a. State	10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
ţò	MD	Prince (George's	Rive	rdale					1 □Yes 2 XNo		
irec	10e. Street and Nu	mber			10f. Zip Code					. Citizen d	of What Co	untry?
ᇛ	5632 67t	h Avenu	е		20737 U					JSA		
ner	11. Marital Status	-	12. Was Decedent	Ever in U.S	. 13. \	Nas Decedent of I	lispanic Orig	gin? (Specify	Yes or No-	14. Race - American Indian,		
Fu		ied 2 Marrie	Armed Forces		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Black, White, etc.		
by	3 X ☐ Widowed	4 Divorced	☐ Divorced If Yes, Give Year or Dates:			1∐Ye <i>s</i> 2∭XNo	Specify:			Spec	^{cify:} Whi	.te
ted	(000	15. Decedent's	Education		16a. Deced	dent's Usual Occup	oation	ofoutdoon	16	b. Kind of	Business/	Industry
age	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)											
5		, , , , , , , , ,	3- (Bookke	eper			Be	evera	ge Co	mpany
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)								ame)			
2	Howard Norton Mary Louise Manley 19a. Informant's Name/Relationship (Type. Print) George Kirk Deakins/son Mary Louise Manley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 5305 Riverdale Rd. Apt. 13 Riverdale, M											
.										vn, State, 2	Zip Code)	
										e, M	20737	
	20a. Method of Dis	•	_	20b. Pla	ace of Dispo	sition (Name of natory or other pla	ce)	Date	20	c. Locatio	n - City or	Town, State
		LXCremation 3 5 ☐ Other (Spe	□ Removal from State ecify)			rney Cren		09/16	/09 W	odbi	ne, N	ID
	21. Signature of Fu				(2)		ss of Facility	ation	Service	- P.	O. Bo	ox 784
	12010	ly L	to the	MO1		_						Le, MD 21029
	23a. Pert 1. Enter t	the sease, or co	omplications that cause	d the death.								Approximate Interval Between
	shock, or hea Immediate Cause		nly one cause on each l	ine.	00							Onset and Death
	disease or condition resulting in death)	on	a. Du₂tovora:	AC -	3 W	ocre						
		1	Road	a conseque	erice oi).	Jan	Cima	,				
ā	Sequentially list conditions, if any is a finite for as a consequence of): Cause (Disease or injury											
ᆵ	cause. Enter Underlying Cause (Disease or injury					````						
Xa	that initiated events resulting in death)	S	Due to (or as	a conseque	ince of):							
<u>8</u>			d									
an/Medical Examiner			u.									
\$	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome	e of pregnan	су					23d. I	Date of de	livery
	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pregnand Other (specify) _	су				Month	Day Year
ysi	1 ☐ Yes 2 ¶ 9 ☐ Unknown	VZTINO I	9 ☐ Unknown									
Completed by Physic	Part II. Other signi	ficant condition	s contributing to death	out not result	ting in the ur	nderlying cause giv	en in Part I.		23e. Did toba	cco use co	ontribute to	the cause of death?
D D	Care	Irae	arren	uth	mic	L			1 ☐ Yes	2.0 No	3 □ P	robably 4 Unknown
ee	Par	et 1 +	Timores	U					24a. Was an	24	h Wara ai	utopsy findings available
핕	1000	OVOL U	WYKOL						autopsy		prior to death?	completion of cause of
	SGN	WITTON	n Cell C	anc	Mo	ona o	em		performe 1 ⊡Yes 🥦	1No	1 ☐ Yes	2 □ No
a	25. Was case refer examiner?		Hospital:			Ott	26. Place	of Death (Cf	eck only one)			
유	1 Yes ₹₹	FNe_	28a. Date of Inj		R/Outpatien 28b. Time of	IL 3LI DOA	4 Li Nur		5 Resident Describe how		- ' '	ecify)
틸	Natural	5 Pending	(Month, D	ay, Year)	Injury	Wor	k?	l	Describe now	injury occ	uneu	
<u></u>	2 Accident investigation M 1 Yes 2 No									at and Alu	mhor or D	ural Pouta Number
<u> </u>	3 ☐ Suicide	6 Could no	3 Suicide Su									urar riodie rvamber,
ertifica	3 ☐ Suicide	6 Could no	ad 28e. Place of In	tc. (Specify)								
Certifica	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	ed 28e. Place of In building, e	tc. (Specify)		n annumed at the s		d alass and	- to the sec	10.e/a) and		e atatad
lical Certifica	3 Suicide 4 Homicide 29a. Certifier (Check only	6 Could no determine	Physicien: To the best	tc. (Specity) t of my know of examinati	ledge, death	h occurred at the t vestigation, in my	ime, date and opinion, deat	d place, and th occurred a	due to the cau	use(s) and e and plac	manner a	s stated. e to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene per me,g897,11/06/09dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Year **Physician** September 10,200 Virginia Ann Dillard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Hospital Lanham Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 06/03/1924 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 255–32–6277 6 Sex **Funeral** Months Days 1 □ M 2 🛛 F Georgía Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, "he Madeal Even, from north or nother deal 1 Yes 2 □ No Director Maryland | Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20715 12114 Long Ridge Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event, the Mas Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Satterfield Ernest P. Hornsby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Douglas C. Dillard/Husband 12114 Long Ridge Lane, Bowie, Maryland 20715 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Arlington National Cemetery 10/14/2009 Arlington, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Rome 21. Signal e of Superal Service Licensee 22. Name and Address of Facility George 1. Ra
2973 Solomons Island Road, E

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 2973 Solomons Island Road, Edgewater, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician CERTIF Physician/Medical as the b IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) the 9 Unknown 9 Hlnknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 1 ☐ Yes e Hospital or Attending Physician: 7 24 hours after death.
Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ZENO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred сотрые filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Textender 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 3118 Good

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 R

ORIGINAL

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Malvis Duffy 9 18 2009 8:50P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shangri-La Assisted Living Ellicott City Howard Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Days Hours 215-46-3270 88 1/9/1921 Wales Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6155 Shadywood Rd. #104 21075 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates Specify Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home is marked other Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Eleanor Lewis 2 George Parke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 6155 Shadywood Rd #104 Elkridge Md 21075 John Duffy - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 9/19/09 Hanover, PID 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Libense M00845 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 20 yrs. Alcoholism / /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease on Flury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the 9 Unknown <u>~</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown End Stage Liver Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has l irector, page 2 s performed? 2X No Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Asst. Living 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation ours after death.

neral Director: f
y filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and mainner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li, 8600 Snowden River Pkwy #301

32. Pegistrar's Signature

D56531

Columbia, MD 21045

Sept. 19, 2009

VOID
CERTIFICATE #

09-31666

SEE

CERTIFICATE #

Fetal 09-781

State
Registrar

DHMH 17 Rev 1/2001

H301

Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar Amend#5.PerFHPGC9-24-09cr 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 15,2009 1530^M September **PPOT** Ρ. Estes 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Fort Washington Hospital 8. Date of Birth (Month, Day, Year) Nov. 26, 1968 Birthplace (State or Foreign Country) 5. Social Security Number 89 Days Hours Months 1 X M 2 □ F NJ 40 579-08-1469 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 No Oxon Hill PG MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20745 4803 Wheeler Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: Black 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Copy Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joanne Cooke Estes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2823 4th St., NE #2
Washington, DC 20002 19a. Informant's Name/Relationship (Type. Print) Priscilla Estes/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 9/23/09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale, Md. Riverdale Park Cremátory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 ducue 23. P 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Due to (or as a consequence of): ongenita Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conse uence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Tllnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant copditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 \(\text{Nursing Home} \) \(5 \) \(\text{Residence} \) \(6 \) \(\text{Other} \((Specify) \) 1 ☐ Inpatient 2 ◯ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Injury 5 ☐ Pending investigation 1 Natural 2 Accident

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran of Vital Records, P.O. Box 68760, ned by the a cate has been signed by page 2 should be detach certificate director,

this funeral

Physician

/Medical

Examiner

Funeral

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examinar outst be notified at

7 Is marked other traumatic event,

permit. Pages Department of Important: If it any Injury or o

Physician /Medical

Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of

Director

by Funeral

Completed

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Certification: To

3 Suicide 4 Homicide

(Check only one)

death with the Maryland

s after death.

I Director: A in by the form n 24 hours af ie Funeral Di bletely filled in Hospital completely the the 2

Medical

6 Could not be determined

29b. Signature and title of certified

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8507 UNUN HALL Rd #102 FT. WASK Anderson MO

31. Date filed (Month, Day, Year)

32. Registar's Signatur

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

State of Maryland / Department of Health and Mental Hygiene 4 amend 20a-22 per hosp. g896 Cerl Mical 1996 Eleath 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Forreste **Physician** Month OS 2009 unge /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sinai Itaspita Baltimor Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland Min. Year) 1 □ M 2 12 F unknasi **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Baltimore **Funeral Director** 10f. Zîp Code 10e. Street and Number 10g. Citizen of What Country "natural", or items 23a or Mall Road 2121 tall permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other traumatic event and any injury or other event and any injury or other event and any injury or other event and any injury or other event and any injury or other event and any injury or other event and any injury or other ev 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 1 No Specify: Black Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknow IN KNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shavonya Evonne Taylor rara ဥ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) hawnya E. Taylor. 4208 Pall Mall Road Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ When (Specify) hospital Sinai Hospital 11/4/09 Baltimore, MD. 22. Name and Address of Facility
Sinai Hospital 2401 W. Belvedere Ave 21. Signature of Funeral Service Licensee teresa Walker 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician -Xtreme disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transli Physician/Medical Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Fregnant at time of death
9 ☑ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 5 ☐ Other (specify) the 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autópsy performed: 2 No 1 ☐ Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Many er of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 5 Pending investigation n 24 hours after death.

ne Funeral Director: Aft
pletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated within 2 To the 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ychman De Resident 2401 ammi Jest belvedere, Baltimore, m.D. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** O^C 1230 Rosalie Douglas Fleegle 9 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany wmHS-Braddock CampuS Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 💢 F 80 218-24-8797 Virginia Director 03/11/1929 West Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🎇 No Director MD Allegany Corriganville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11400 Featherbed Lane Be Completed by Funeral 21524 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Edward McClellan Ethel Marie McKenzie ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 341, Corriganville, MD Deborah F. Lyddane / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Vet Cem @ Rocky Gap 09/23/2009 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a ATHEROSCLEROTIC CARDIOVASCULAR UNKNOUN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in lighted exercises) Examiner Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ ARTERIAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Donatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Hoss State

within 2

2

DHMH 17 Rev 1/2001

Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

21

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

amm

29c. License number

Drive,

29d. Date signed (Month, Day, Year)

21502

For

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Marked Evaninar must be neithed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Registra

1 - Registrar Certificate of Death						g. No.	01011				
	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death				
ian cal	Kenneth Nathaniel Flemmin	ıgs			Septembe	r 15, 2009	8:30 A M				
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death					
	6002 Wesson Drive		Suitland			Prince Ge	orge's				
		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign intry)				
	579-88-3086 1 ¹ X ^{M 2□ F}	49 Yrs.	Months Days	Hours Min.	Aug 18,	1960 Wash	ington, DC				
	Usual Residence of Decedent										
L	10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No				
양	MD Prince George's	Suitland	and								
ire	10e. Street and Number		10f. Zip Code	g. Citizen of What Cou	intry?						
a L	6002 Wesson Drive		20746		SA						
ner	11. Marital Status 12. Was Decedent Ev	ver in U.S. 13. W	as Decedent of H	14. Race - Amer							
F	Armed Forces? 12 Never Married 2 Married 1 □ Yes 2 2 No.)	Yes, specify Cuba	Becedent of Hispanic Origin? (Specify Yes or Noss, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.							
by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		LIYes 2 MAINO	Specify: Blac	ck						
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호		life. D		during most of work t)							
5	Elementary/Secondary (0-12) College (1-4or 5+	Electr	ician			Electric					
Be (17. Father's Name (First, Middle, Last)				e (First, Middle, M	·					
2	Leroy James Flemmings			Sylvia H	Estelle L	ucas					
-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	g Address (Street	and Number or Ru	ral Route Number,	City or Town, State, Zi	ip Code)				
Leroy J. Flemmings/brother 6002 Wesson Drive Suitland, MD 20746											
	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Str.										
	1 Burial 2 Xcremation 3 Removal from State 4 Donation 5 Other (Specify) Removal from State 4 Donation 5 Other (Specify) Removal from State 5 Other (Specify) Removal from State 6 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal from State 7 Other (Specify) Removal fr										
	21. Signature of Funeral Service Licensee	1				<u> </u>					
	21. Signature of Funeral Service Ligensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029										
	23a. Part 1. Enter the 1st ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.										
	shock, or heart failure. List only one cause on each line			9 , - · • · · · · · · · · · · · · · · · · ·			Interval Between Onset and Death				
	disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of):										
	Ventricular Tachycardia										
눖	Sequentially list conditions, if any, leading to immediate by the for as a sensequence of .										
Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	301133 qu 31133 317.									
/Medical Examiner	triat initiated events	consequence of):					· · · · · · · · · · · · · · · · · · ·				
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g	d										
/Me	IF FEMALE: 23c. If yes, outcome o	f pregnancy				0015441					
	in the past 12 months?	! ☐ Fetal death 3 ☐	Ectopic pregnancy	у		23d. Date of deli	very Day Year				
ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 1 9 ☐ Unknown 9 ☐ Unknown	illie of death 5 🗆	Other (specify)								
Completed by Physicial	Part II. Other significant conditions contributing to death but	not resulting in the uni	derlying cause give	en in Part I	23e. Did tob	acco use contribute to	the cause of death?				
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Be (25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one						
		t 2 ER/Outpatient	3 □ DOA Othe	er: 4 Nursing H	ome 5X Reside	nce 6 ☐ Other (Spec	rify)				
ü	27. Manner of Death 1. Whatural 5. Pending (Month, Day,	(28b. Time of Injury	28c. Injury Work	y at	28d. Describe how	w injury occurred					
atic	1 Matural 5 Pending (Montin, Day, 2 Accident investigation	, ,,,,,,		Yes 2 □No							
E E	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur building, etc.	y - At home, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui	ral Route Number,				
Se l	building, c.c.	(Opeony)			City of Town,	, Siale)					
) ja	29a. Certifier 1 X Certifying Physician: To the best of	my knowledge, death	occurred at the tir	me, date and place	, and due to the ca	ause(s) and manner as	stated.				
Medical Certification: To	(Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or inv	estigation, in my o	pinion, death occu	rred at the time, da	ate and place, and due	to the cause(s)				
ğ	29b. Signature and title of cortifies	29c. License number 29d. Date signed (Month, Day, Year)									
	10,600		MD3283	6	S	eptember 1	7, 2009				
	30. Name and address of person who completed cause of dea	ath (Item 23a) (Type P	Print)								
	Reginald L. Robinson, M.D.			Suite 270	ON Wachi	naton DC	20010				
ite	31. Date filed (Month, Day, Year) 32. Begistrar	's Signature		DULCE 2/	ON WOSLIT	inguit, D.C	20010				
ar	SEP 18 2009 Serven	2 B. La	ake								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $^{\text{Day}}_{17}$, 2009**Physician** September 10:23 P.M Celia Freed /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Copper Ridge Nursing Home Carrol1 Sykesville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 04/19/1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 025-01-7340 Director 100 Vermont Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 TXYes 2 □ No MD Carrol1 Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 31 Kemper Avenue 21157 USA Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2★ No Specify. <u>Ş</u> Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mental once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Draisen ပ Dora Margolin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moses Goldberg / son 31 Kemper Ave. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest Lawn North
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ₺ Burial 2 □ Cremation 3 ₺ Removal from State 09/22/2009 Pompano Beach, FL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc
1170 Rockville Pike Rockville, MD 20852 21. Signature of Fund Service Licensee W01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (ews disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): the attending physician ned for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by the a d be detached for ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 □ Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has I page 2 s 24a Was an autopsy certificate 1 🗆 Yes 2 1 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) P. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 5 Pending death. 1 □Yes 2 □No 2 Accident investigation Director: , 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 Homicide within 24 hours a

To the Funeral [Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) ၉ 120059943 18,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pagy 295 WeSminster sun (Mermo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 21 2009 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle, Last) 3. Time of Death September 15, Year 2009 Day **Physician** Macie Elswick Groves 3:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Prince George's Crofton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days 224-20-4148 91 1 □ M 2 🔯 F Director Feb 23. 1918 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations to be publical and once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Calvert Huntingtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3861 Moonbeam Avenue 20639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed by 3 ₩ Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alvin (Unknown) ပ Elswick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Groves (daughter-in-law) 3861 Moonbeam Avenue Huntingtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept Date 19 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Chicamuxen UMC Cem. 4 Donation 5 Dother (Specify) 2009 Indian Head. MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Fundal Service Licenses GAYYOU. GOTA 8125 Southern Maryland Blvd Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the property. Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D57028 LLM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Aditya Chopra, MD

18 2009

SEP

31. Date filed (Month, Day, Year)

600 Ridgely Ave

32. Registrar's Signatur

Ste 200 Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** Stella Harrington George 2009 Sept 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Preston 3151 Choptank Road 8. Date of Birth (Month, Day, Apr. 10, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Year) 1 □ M 2√□xF 214-28-7925 79 Apr. 1930 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the World's Examination or colling 1 ☐Yes 2 ☑ No Director MD Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 10687 Ocean Gateway 21601 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1
Yes 2
No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ∐Yes 2x⊟xNo If Yes, Give Specify: Specify: ò 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event, Item M. Elementary/Secondary (0-12) College (1-4or 5+) Produce/Farming Agriculture (Grad. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Guy Harrington Marilla Andrews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella Coulbourne/Daughter 3151 Choptank Rd., Preston, MD 21655 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spring Hill Cem. 09/23/09 Easton, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 65 true tive hronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an performed2 1 □Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No After this of funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation neral **Director**: A filled in by the fu 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of cerying

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ton Con

32. Registrar's Signature

555

29c. License number

inwood Dr

Guston

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** September 16, 2009 10:30 a Mary Helen Harrod /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 11224 Rawhide Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 🛭 F Months Director December 7, 1948 MD 60 214-58-0886 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macical Examiner must be notified at 1 ☐ Yes 2 🕱 No Director MD Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 11224 Rawhide Road 20657 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify. \$ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If Item 27 Is marked of any Injury or other traumatic evenonce. ဥ George Harrod Helen Mae Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4019 Blackbird Court, Waldorf, MD 20603 Iris Woodland - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ches. Highlands Mem. Gardens | September 21, 2009 | Port Republic, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sewell Funeral Home, P.A. Dadlep 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final cholangio cardinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intime diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Osteogotuits Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy 2 N 1 ☐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 1 Yes 2 ₩o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 1 8 2009

Shu

Medical

and manner stated

130

32. Registrar's Signature

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D 50290

RILLY

29d. Date signed (Month, Day, Year)

9-18-09

20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2:45 AM **Physician** 0 9 Adel Marie Hughes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Manor Care Ruxton Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jun 25, 1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 284-20-0781 1 □ M 2 🔀 F 83 Ohio Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "natural" or frame any injury or other trainment. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director MD Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7001 North Charles Street 21204 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adel Kratz William Glynn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frederick Hughes/Son 809 S. Montford Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Sept. 18, 1

Burial 2 □ Cremation 3 □ Removal from State MD Veteran's Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 Severna Park, Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** emeni /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Proknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed' 2 No certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check onli one funeral director, Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide within 24 hours at To the Funeral L Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 4-054424 9-15-0929b. Signature and title of certifier 29c. License number

State Registrar

Hammonds lane # L2 Brooklyn, MD 21225 15adi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:29 A M Mary Johnson Hughes 21 2009 Sept. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Caroline Nursing Home Denton Caroline If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Days 1 □ M 2 X F $95^{Yrs.}$ 214-30-8159 13, 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland | Caroline Goldsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26540 Sandtown Rd. 21636 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1·□ Yes 2X No 3X Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Lab Technician Plastics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George C. Johnson Emma A. Clayville 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Rebecca Weaver/Daughter 12583 Ridgely Rd., Greensboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State

29d. Date signed (Month, Day, Year)

Physician /Medical

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner

ed by the attending physician detached for use as the burial To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. I

Division or Vital Records, P.O. Box 68760,

	4 ☐ Donation 5 ☐ Other (Specify)	H	lopkins Cem	etery Sept	.26,2009 Fe	lton, De	elaware
	21. Signature of Funeral Service Licens	ee Lugh	22. Name Flee 106	and Address of Facility gle and Helfe W. Sunset Ave	enbein Funer	al Home	yland 21639
Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):	node of dying, such as card	ac or respiratory arrest,	hav	Approximate Interval Between Onset and Death
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3 □Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
ed by PI	Part II. Other significant conditions con	ntributing to death but not r	esulting in the underlyin	g cause given in Part I.			to the cause of death? Probably 4 ∐Unknown
Complet					24a. Was an autopsy performed 1 Yes 2	prior to death?	autopsy findings available completion of cause of s 2 \(\sum \) No
Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
To.	1 Yes 2 No	lospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Sp	ecify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury · At building, etc. (Spe	home, farm, street, fact	ory, office	28f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,

DHMH 17 Rev 1/2001

State

Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 2 5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Zaki 920 Market Street, Denton, MD

1 retrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21629

29c. License number

Doo47534

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of M	aryland / I	Department of F Certificate of			iene 2	31579
			Decedent's Name (First, Midd				2			3. Time of Death
Physician /Medical			Charles	Frankl	Franklin		Jones		er 21, 200	09 6:30 A M
1	Examin	er	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death		-	4c. County of Dea	
***	Funeral Director		Lions Ctr for 5. Social Security Number 218–16–4844	6. Sex 7. Ag	xt. Care _{Je (In yrs. last bi} 37		erland If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/26/1	Year) 9. Bii	egany httplace (State or Foreign ountry) est Virginia
	ס		Usual Residence of Decedent		I (0. 0): 7					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Moulect Examiner must be notified at Once.	Funeral Director				n or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
			MD A	llegany	iy Cu		Imberland 10f. Zip Code		0g. Citizen of What Country?	
		Ö	12504 Bowling Street, SW		21502		1502		USA	,
21215-0036		nera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of H		ecify Yes or No-	14. Race - Am	
		b	1 ☐ Never Married 2 💢 Mar 3 ☐ Widowed 4 ☐ Divorced		[№] 1942 – 1946	1 □Yes 2 NNO		Hican, etc.)	Black, Whi	White
5-0		lete	15. Deceder (Specify only highe	nt's Education est grade completed)	16a	Decedent's Usual Occup (Give kind of work done life, DO NOT use retire	nation during most of work	ing	16b. Kind of Business	s/Industry
121		To Be Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		a)		m . 1	
			17. Father's Name (First, Middle	, Last)		Laborer	18. Mother's Name	e (First, Middle, M	Televisi Maiden Surname)	on
ılan			Lewis	Franklin	Joi	nes	Nellie	Gra	ace S	tewart
Baltimore, Maryland			19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12504 Bowling Street, SW, Cumberland, MD 21502							
			20a. Method of Disposition 1		/	of Disposition <i>(Name</i> of ery, crematory or other plant t Memorial P	ark 09/2	3/2009	20c. Location - City of Cumberla:	nd, MD
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Adams Family Funeral Home, P.A 404 Decatur Street, Cumberland, MD 21502							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property in the funeral director.	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between							
and the			Immediate Cause (Final disease or condition Athoro Scleratic Cardio Vascular disease Condition							
and the			resulting in death) Due to (or as a consequence of):							
i.			Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	b					
			cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ			resulting in death) Last	Due to (or as	a consequence	of):				
68760,		Be Completed by Physician/Medical		d						
O. Box			IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Data of d	olivery
			23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	h 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day Year		
rds, P.			Part II. Other significant condit	in the underlying cause giv	nderlying cause given in Part I. 23e. Did tobacc 1 ☐ Yes			co use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown		
of Vital Records,								24a. Was a autops perforr	sy prior to med? death?	autopsy findings available completion of cause of
tal			25. Was case referred to medical	al			26. Place of Deat	1 □Yes 2 h (Check only on	2 No 1 □Ye	s 2 No
f V		To B	examiner? 1 Yes 2 Mospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							ecify)
Division o		Certification: T	27. Manner of Death 1 ✓ Natural 5 ☐ Pendi	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?						
			2 ☐ Accident invest	igation not be	he					
			4 ☐ Homicide deter			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
_	To the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complet	Me	7 1						nth, Day, Year)	
	5+		Monson	alle	MD	Doc	55325		Sept 2	,2009
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCK SHIP MD 925 Bishop Wulsh Rd Comberland Me							ul MD 2	15-02		
State Registrar SEP 2 2 2009 Service A. James State SEP 2 2 2009										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 7 **Physician** 2009 Charles Johnson Jr 10:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Marley Neck Health & Rehab Glen Burnie Anne Arundel 8. Date of Birth Month, Day, AUG 8 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**X** M 2□ F Maryland 214-38-2423 70 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10h Counts 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Eventine is ust by northed at Director Maryland Anne Arundel 1 □Yes 2√∑No Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Dennis Rd. 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 2 If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7th n Butcher Food Land permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Johnson Sr Martha Wallace ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Coates(Sister) 111 Dennis Rd. Severna Park, Md. 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Carpenter's Hill 9-11-09 Severna Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) WinName Reddes of SaciliSons Mortuary, 21. Signature of Funeral Service Licenses P.A. M00482 1.7 Harry cese 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) executed and burial-tran Due to (or as a consequence of): attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) ed by the signed by 1 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacceruse contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) use of beath (Item 23a) (Type, Fri

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

Division of Vital Records, P.O. Box 68760.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 13, 2009 Marjorie E. Kroll /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany Lions Care Center Cumberland Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗷 F Yrs. 87 December 02, 1921 Maryland 215-16-4603 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location sa or 28a-f show t be notified at 10a, State 10b. County 1 XYes 2 No Director Maryland Mt. Savage Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must b 21545-14715 Mullaney Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MHNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🖫 No Baltimore, Maryland 21215-0036 Specify: ģ 3 M Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) school cafeteria cafeteria worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Marie Sween Joseph B. Lynch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21545self 14715 Mullanev Ave. Mariorie Kroll Mt. Savage 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept 17.2009 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Savage St. Patrick's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Takola. Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovascular **Physician** Atherosclosofic 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to for as a consequence of Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DQA 1 ☐ Yes 21**X** No 1 Inpatient 2 ER/Outpatient Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; and completely filled in by the f 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

n Ls

DHMH 17 Rev 1/2001

the

State Registrar

29b. Signature and title of certifier

onochski

29c. License number

D0055325

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ivia	ryland / Dep <i>Ce</i>	ertificate of			eg. No.			181
	Dhamini		1. Decedent's Name (First, Middle, Las	st)				Date of Deat Month	h Day	Year	3. Time of E	
	Physici /Medic		William	Russ	ell	Kline		Septemb	•	2009	0540	М
AND.	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	Dopomo	4c. Count	y of Death		
1			Momorial Hosptial			Cumber	cland		A	llegar	av	
	Funeral Director		Memorial Hosptial 5. Social Security Number 6. S 236-50-0770 Usual Residence of Decedent		(In yrs. last birthda) 82 Yrs.	/) If Under 1 Year Months Days	I and If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 06/22/1	Year) 927	9. Birthpl	lace (State or try) Virgi	Foreign .nia
	fand bw		10a. State 10b. County		10c. City, Town or I	_ocation				10	0d. Inside City	/ Limits
	Mary	Ď	WV Miner	al		Wiley	Ford				1 □Yes	2) No
	the 28a	rec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Coun	try?	
	with with		Route 1 Box	16			26767			USA		
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Modical Evel, her cust be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 □ No If Yes, Give Ye ar or Dates:	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🏋 No		pecify Yes or No- Rican, etc.)		ace - Americ ack, White, e		
Maryland 21215-0036	hour tural	pa	15. Decedent's Ed		16a Dec	edent's Usual Occup	pation	T	16b. Kind of E			
5	n 72 ''na	let	(Specify only highest gra	de completed)	(Giv	e kind of work done DO NOT use retired	during most of work	ring	,,,		,	
12	within ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Dairy Far			1	arm		
2	al Hygi other		17. Father's Name (First, Middle, Last)			Dairy rai	18. Mother's Nam	e (First, Middle,				
an	be od o	Be	Hubert	Murril	1 K1	ine	Nora		ola	Owe	ens	
Ë	should be and Ments marked umatic er	욘				iling Address (Street						
a	2 se har		19a. Informant's Name/Relationship (Richard L. Kline		l l	ce 2 Box 4					0000)	
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition	7 5011					20c. Location		wn. State	
ō	Pages 1 and iment of Healt tant: If item 21 jury or other t		1 M Burial 2 ☐ Cremation 3 ☐	Removal from State		position (Name of ematory or other place						
Ë	t. Pa tmer tant: ijury		4 □ Donation 5 □ Other (Specif			Memorial						D A
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ocer	am		22. Name and Addre 404 Deca	tur Stree		•		21502	_
per s.	Physician /Medical Examiner	Examiner	23a. Part 1. Emir the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, could be founded by the cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury	a Due to (or as a	e.	VV4 Scc	1	accie	0		Approximate Interval Betwonset and D	eath
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	that initiated events 'resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a d	2 ☐ Fetal death	B ☐ Ectopic pregnands ☐ Other (specify) _	ey .			Date of deliver		⁄ear
ds, P.	ires that signed b	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.		bacco use co es 2 □ No			
Vital Records,	:: The law requires t icate has been signs ; page 2 should be t	Completed						24a. Was an autopsy performed? performed? 1 \(\text{Yes} \) 2 \(\text{No} \) No		available ause of		
Ĭ,	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea					
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Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: T	2 Accident investigation 3 Suicide 6 Could not be determined		rry - At home, farm, (Specify)	-		28f. Location (S City or Tow	Street and Nur rn, State)	nber or Rura	al Route Numi	ber,
	ne Hospital or n 24 hours afte ne Funeral Dir pletely filled in I	Medical (29a. Certifier (Check only one)	nysician: To the best on niner: On the basis of and manner sta	examination and/or	eath occurred at the to investigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and date and place	manner as s e, and due to	stated. o the cause(s))
	To the P within 24 To the F complet	Me	29b. Signature and title of certifier	10		29c. Licen	se number		29d. Date sign	ned (Month,	Day, Year)	
	5+		///			D2676	6	c	eptembe	ar 01	2009	
	0+		30. Name and address of person who	completed cause of de	eath (Item 23a) (Tvn	D3676 e, Print)	U	D	epremo	-L <u>21</u>	2007	
	LXIK		Vik Poonai,	M.D., 924	Seton Dr	rive, Cumb	erland, N	4D 2150	2			
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 645 AM Mary Lacock Septembe 18 POOG 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvet Frederick Prince Calvert Memorial If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 02/12/1930 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F West Virginia 234-42-4979 79 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Lusby Calvert Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20657 11905 Oyster Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ada Burns Lloyd Wilmoth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11905 Oyster Court, Lusby, MD 20657 Gail Chenevey / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 Removal from State 09/24/2009 Huntington, West Virginia Spring Hill Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Staphylococcus Methicillin Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3□Ectopic p		2	3d. Date of delivery Month Day Year	
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?	
Right upper	· lobe lung	mass		1 ☐ Yes 2 [□ No 3 □ Probably 4 ☑ Unknow	
				24a. Was an autopsy performed? 1 Yes 2 Mo	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ★ No	
25. Was case referred to medical			26. Place of De	ath Check onl one		
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatient 3 ☐ D	Home 5 ☐ Residence 6	e 5 ☐ Residence 6 ☐ Other (Specify)		
27. Manner of Death 1 Manural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury		
3 Suicide 6 Could not 4 Homicide determine		nome, farm, street, facto		8f. Location (Street and Number or Rural Route Number, City or Town, State)		
	Physician: To the best of my kn aminer: On the basis of examin and manner stated.				and manner as stated. d place, and due to the cause(s)	

29c. License number

D67594

Prince Frederik,

29d. Date signed (Month, Day, Year)

September 18, 2009

20678'

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chery Ltep, MS 100 the pital Ro

31. Date filed (Month, Day, Year)

SEP 21 2009

Annual

MIS

29b. Signature and title of certifier

State Registrar

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of I rtificate of			giene 2 () () ()	3 1683		
	Physici		1. Decedent's Name (First, Middle, L Charles Stuar	*				2. Date of Dea Month 09/	th 17/2009 Year	3. Time of Death 07:00 atm		
The same	/Medio Examir		4a. Facility Name (If not institution, g. 420 W. Dares E				or Location of Death	rick	4c. County of Death Calvert			
	Funeral Director		5. Social Security Number 6. 265–38–2214	Sex 1 M 2 □ F 7. Age	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 08/16/1	9. Bii 931	thplace (State or Foreign ountry)		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits		
	Maryli -f sho	tor	MD Calve	rt	Prince :	Frederic	ζ			1 ☐Yes Ž☐No		
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?		
	ath wi		420 W. Dares Be				20678	" "	U.S.A.	1 1 1		
336	172 hours after death with the Maryland "natural", or items 23a or 28a-f show office From the could be could	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	lo l	Was Decedent of If Yes, specify Cub 1 □Yes 2XNo	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Cif-	14. Race - American Indian, Black, White, etc. Specify: White		
2-0	72 hou natura fical E	eted	15. Decedent's E	Education	16a. Dece	dent's Usual Occu	pation during most of worki	ina I	16b. Kind of Business	/Industry		
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) `life.	DO NOT use retire tter Cari	ed)		U.S. Post	Office		
d 2	Hyg The		17. Father's Name (First, Middle, Las	et)	110	cter cari	18. Mother's Name	(First, Middle,		OTTICE		
'lan	12 should h and Mer 7 is marke traumatic	To Be	Stuart Lockhar	t			Rebah W	aldron				
, Maryland 21215-0036			19a. Informant's Name/Relationship Carol Lockhart/	(Type. Print) Wif e					r, City or Town, State, nce Freder			
Baltimore,	es of of r		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 d ☐ Dopation 5 ☐ Other (Spec		20b. Place of Dispo cemetery, crea MD Veter	matory`or other pla	^(ce) 09/23)/2009	20c. Location - City o	r Town, State		
Balt	permit. Pag Department Important: I any Injury o once,		21. Signature of Funeray eyvice Lice Lisa M. Jount	/ /	2	2. Name and Addr 8125 Sout	ess of Facility Lee Chern_Md_B	Funera	l Home Cal wings, MD	vert, P.A. 20736		
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O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	⊒Ectopic pregnan ⊒Other <i>(specify)</i>	су		23d. Date of d Month	elivery Day Year		
о, С.	s that the ined by the e detach	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?		
ords	requires been sign should be		Madden 64V	scolor a	4			1 🗆 Y	'es 2 □ No 3 □ I	Probably 4 1 Unknown		
al Records,		Completed	Perpheral Use	sculor a	disease			24a. Was a autop perfor 1 □ Yes	sy prior to rmed? death?	autopsy findings available completion of cause of s 2 □No		
Vital	Physician: r this certificatal director, it	Be	25. Was case referred to medical examiner?	Hospital:		Ot	26. Place of Death					
of	Physer this eral di	<u>1</u> کا	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ry 2 ER/Outpatie	III 3 LI DOA	4 Li Nursing Ho	/	dence 6 Other (Sp now injury occurred	ecify)		
ion	Attending For death. ector: After by the funerations	atio	Natural 5 ☐ Pending 2 ☐ Accident investigati	(<i>Month, Da</i> on	y, Year) Injury		rk?]Yes 2 □No					
Division	tal or Attenders after death	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	Street and Number or f vn, State)	Rural Route Number,		
	To the Hospital or within 24 hours after To the Funeral Directory (Completely filled in Line and Completely filled in Line and	Medical (29a. Certifying I (Check only one) Certifying I 2 Medical Ex-	Physician: To the best aminer: On the basis o and manner sta	f examination and/or in	th occurred at the nvestigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and di	as stated. ue to the cause(s)		
	Vith vith com	Σ	29b. Signature and title of certifier	Danie D	20-4	29c. Licen	se number 9 4 9		29d. Date signed (Moi	nth, Day, Year)		

State Registrar

31. Date filed (Month, Day, Year) SEP 18 2009

Dr. Champaloux, M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Champaloux, M.D.

14314 Old Marlboro Pike, Upper Marlboro, MD 20772

State of Maryland / Department of Health and Mental Hygiene

		For State of Mary State Registrar		tificate of L			Reg. No.	9108	
Physicia /Medic		1. Decedent's Name (First, Middle, Last)	LE	ACHE		2. Date of De	10 200 Year	8:401 W	
Examin	er	4a. Facility Name (If not institution, give street and number) Vantage House		4b. City, Town, or Colum			4c. County of De		
Funeral Director		5. Social Security Number 6. Sex 1 → 7. Age (Int. 1 → M 2 → F	n yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 3/13/	1921 Pe	rthplace (State or Foreign Country) nnsylvania	
anyland show d at	7		c. City, Town or Lo		<u> </u>			10d. Inside City Limits	
the M 28a-f notifie	recto	Md. Howard 10e. Street and Number	Colu	mbia 10f. Zip Code			10g. Citizen of What 0		
h with 3a or st be	al Di	5400 Vantage Point Rd.		21044			USA	•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	1		
72 hou natura dical E	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	ient's Usual Occupa	during most of wor	king	16b. Kind of Busines	s/Industry	
within ane.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4yrs	life. L	00 NOT use retired omemaker	1)		Own h	nme	
filed v Hygie other ent, th		17. Father's Name (First, Middle, Last)	1 12	and hares	18. Mother's Nam	ne (First, Middle	, Maiden Surname)	AIRC	
Mental Mental arked o	To Be	Robert Conrad Waldick Cade		GAULTER THE T	Rose D	eMarco			
2 should and Men is marke		19a. Informant's Name/Relationship (Type. Print)	6.0	•			er, City or Town, State	,	
1 and 2 Health em 27 isther tr		Suzanne A. Gearhart/daughter	4533 20b. Place of Dispo		p Ct. El	licott (City,Md. 2		
Pages nent of H int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	natory or other plac			Hanover,	·	
artme ortani injury		21. Sign thre of Equipment Service (Cicensee	Ardent C	rematory 2. Name and A res	Inc: 9/1	7/2009 I	tzke's Fam		
permit. Departr Imports any inj		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	4.	TTS OTG C	olumbia	Pike El	licott City	7.Md. 21043	
Medical Examiner B buysician and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause). Due to (or as a condition of the cause).	insequence off	s D7	seast				
requires that the death certificati een signed by the attending phy rould be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnant at time past 12 months? 4 □ Pregnant at time po □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/	23d. Date of d Month			
luires that n signed to ild be deta	þ	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onk			
The law ate has b page 2 sl	Completed					1□ Yes	ppsy prior t ormed? death 2 ☑ No 1 ☐ Y	es 2 No	
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	ot 3 DOA Oth	er: 4 D Nursing H	,	one) Vanta idence 6 Other (S)		
Attending Physic death. ector: After this by the funeral di	tion: To	27. Mann f Death 28a. Date of Injury 1 Inflatural 5 Pending (Month, Day Year 1 Accident 1 Pending 28b. Time o	f 28c. Injur Wor			how injury occurred	ecity)		
in the state of	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (5	eet, factory, office		28f. Location (City or To	(Street and Number or own, State)	Rural Route Number,		
Hospital	Medical	29a. Certifier (Check only one) 1	amination and/or in	h occurred at the tirvestigation, in my c	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and manner , date and place, and c	as stated. lue to the cause(s)	
To the within 2 To the comple	Med	29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mo	nth, Day, Year)	
F > F 0		> KNAGELS ND			3587			7,2009	
1 De-		30. Name and address of person who completed cause of death 300 Amory PUS	h (Item 23a) (Type,	Print) KEN	NETTO	URA	14, MD MD 21	201.	
Sta	ite	31. Date filed (Month, Day, Year) 32. Figistrar's		1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🦻 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Bruce Oliver Lecates 2009 /Medical eptem her 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** REGIONAL MEDIEAL FENINSUCA 5. Social Security Number NICOMIC 54613640 If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Months Days Hours Mir **Director** 216-38-8356 69 1940 Maryland March Usual Residence of Decedent 10a. State 10b. County works ! 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Medical Eventure must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13581 Dahlia Court 21639 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Q Q Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 721 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other than 91 july or other traumatic event 4 Minister Church 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Oliver James Lecates Gertrude Robinson Lecates 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Lecates/Spouse 13581 Dahlia Court, Greensboro, Maryland 21639 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. 28,2009 Salisbury, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility Fleegle and Helfenbein Funeral Home 106 W. Sunset Ave., Greensboro, Maryland 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical ass IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 2 KNo this certificate 1 □ Yes 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 □ Yes 2 🗆 No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Chris

3N4DE

31. Date filed (Month, Day, Year)

CARROI

Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 8

/32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 20, 2009 Sept. John Samuel Lewis, Sr. 6:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Home for Hospice Denton Caroline 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 25 19 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F 41 Director 217-98-6513 1968 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examines must be realther an once. 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1. Yes 2 □ No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PO Box 570 21639 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Tho Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 XNo ģ If Yes. Give Specify Specify: 3 ☐ Widowed 4 🖾 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) appraiser real estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel T. Lewis ဥ Patricia Gee Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia G. Lewis/ #3 7th Street; Ridgely, Maryland 21660 mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery 4 Donation 5 Dother (Specify) 09/25/2009 Greensboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** uob ast oma eays disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 ZN 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) CAROLINE HOME Other: 4 Nursing Home 5 Residence 6 Nother (Specify) FOR HOSPICE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 2 Accident 1 ☐ Yes 2 🗆 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 057749 SEPTEMBER 23, 2009

State Registrar

DHMH 17 Rev 1/2001

219 S Washington Street, Easton, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Lakshmi Vaidyanathan

SEP & 5 ZUUS

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

/Medical

Examiner

and burial-trar

physician

signed I

in by the

24 hours a completely filled

within 2 To the

the as attending I for use as

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene

		For State Of Wallyland /	Certificate of Death	Reg. No	o
Dhucie	ion	Decedent's Name (First, Middle, Last)			year 3. Time of Death
Physic /Med		Harriett Joan Lade	4b. City, Town, or Location of Death	September 40	18, 2009 2:30 P
Exam	iner	4a. Facility Name (If not institution, give street and number)			Caroline
Funera		Envoy of Denton 5. Social Security Number 6. Sex 7. Age (In yrs. last It	Denton Dirthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	Birthplace (State or Foreign
Directo		506-38-9486 1□M 2XF 76	Yrs.	Nov. 2, 19	
put "		Usual Residence of Decedent	own or Location		10d. Inside City Limits
//anyla	5		isbury		X□Yes 2□No
r 28a- r ontif	Director	Maryland Wicomico Sal	10f. Zip Code	10g. C	itizen of What Country?
th with 23a o 1st be		507 West College Avenue	21801	Unit	ed States of Americ 14. Race - American Indian,
tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Caucasian
III (Z I Z I 3-VU30 be filed within 72 hours after death with the Maryland ntal Hygiene. Indicate than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of work		Kind of Business/Industry
IIIQ ZIZIO-U be filed within 72 h tal Hygiene. d other than "natu	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)		G 11
Maryiand ZIZI3-UU30 d 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	ပြ	12 8 17. Father's Name (<i>First, Middle, Last</i>)	Educator 18. Mother's Nam	ne (First, Middle, Maide	College on Surname)
	Be C		Harrie	tt Rosetta	Adams
should nd Me	ို		9b. Mailing Address (Street and Number or Ru		
		Paul H. Lade Son	2021 Wildwood Trail,	Pocomoke C	ity, Maryland 21851
D - I = =		1 Rurial 2 Remation 3 Removal from State	e of Disposition (Name of etery, crematory or other place)		Location - City or Town, State
Page and;		4 □ Donation 5 □ Other (Specify) Ca	pitol Crematory 9/21 22. Name and Address of Facility M		
balt permit. Departi Importa any inj	2 5	21. Signature of Funeral Service License	12 South Second St		al Home, P.A.
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Physicia		shock, or heart failure. List only one cause on each line.	AGE ALZHEIMER	'S DISSA	Onset and Death
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ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injitated events c.	ce oi).		
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c 68 ertifica ing ph	Med	IF FEMALE: 230 If yes, outcome of pregnancy			20d Date of delivery
Box eath cer attendin for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de	eath 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
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or Vital Records, Physician: The law requires t r this certificate has been signe and director, page 2 should be or	ع ا			performed 1 Yes 2 €	No 1 ☐ Yes 2 No
or Vita Physician: this certific ral director,	å		Other	ath <i>(Check only one)</i> Home 5 □ Besidence	e 6 □Other (Specify)
OF J Phys er this eral di	F	282 Date of Injury 28	Bb. Time of lnjury at Work?	28d. Describe how in	
Vision Attending r death. ector: After	i	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	M 1 Yes 2 No		
Division I or Attending after death. Director: After	Cortification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Stree: City or Town, S	t and Number or Rural Route Number, tate)
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Division or Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Modical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, in my opinion, death occ	curred at the time, date	and place, and due to the cause(s)
To the within 2. To the I	M	29b. Signature and title of certifler	29c. License number	94 29d.	Date signed (Month, Day, Year)
		THE MALL ATTENDING	EMD DOOD	/	1-71-50
		20 Name and addless of person who completed cause of death (Item 2	3a) (Type, Print) 32\ BLOOMINGSA	LE AUE F	7-21-2009 EDSEALSBUEGHD
*57-	State	31. Date filed (Month. Day, Year) 32. Registrar's Signatur	· bash	4	
Reg	istra	SEP 21 2009 Perpa A.	7		

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

	1		rtificate of Death	Reg. N	No. opan olco
Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Sept. 18	3. Time of Death 3 2009 12:26 A.M.
/Medic Examin	al -	Isabelle V. Marani 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	135 45 45	4c. County of Death
Funeral Director		Golden Living Center 5. Social Security Number 1	Hagerstown, Md. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	21740 8. Date of Birth (Month, Day, Yea 07-20-19;	
р	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		10g.	10d. Inside City Limits 1 □ Yes 22 No Citizen of What Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Dire		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
72 hours afte	þ	Year or Dates: 15. Decedent's Education (Give	1 ☐ Yes 2 No Specify: edent's Usual Occupation be kind of work done during most of work DO NOT use retired)		Specify: White Kind of Business/Industry
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1 and 2 should be file. Health and Mental Hyem 27 is marked oth ther traumatic event	으	19a. Informant's Name/Relationship (Type. Print) 19b. Mail RUNGHU J. Marani – Son 81 H	ling Address (Street and Number or Ru	elta, Pa	17314
permit. Pages 1 a Department of Her Important; If item any Injury or othe		1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ematory or other place)	2/09 00	Exclusion - City or Town, State
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature and title of certifier 2 Great Hysician. To the basis of examination and/or and manner stated.	r investigation, in my opinion, death occ	curred at the time, dat	d. Date signed (Month, Day, Year)
•		30. Name and address of person who completed cause of death (Item 23a) (Type	D 28365 De, Print) De, Print) De, Print) De, Print)	of 1409e	9-18-09. vstom 170 21740
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	Cert	tificate of Dea	ath	Reg	. No. 20	09 3158
Physicia	ın/	 Decedent's Name (First, Middle,Las 		10 10		2. Date of Death Month	Day Year	3. Time of Death 1248 hrs
ledical Exami		ADRIAN J	AMES MEC	ILEN BU	=126-	September	7, 2009 4c. County of Dea	
		4a. Facility Name (if not institution, given Union Hospital	e street and number)	4b. City	, Town, or Location of Dea On	1(1)	Cecil	ui
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Director		213-65-4077 1	M 2 F 7	Yrs. Mo	nths Days Hours M	in. JULY 2	0,2002 Fore	country) MD_
	1	Usual Residence of Decedent				/	/	10d. Inside City Limits
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Aaryland 28a-f show 1 at once.	ģ	MD, C/EC	16 /2	151NG 5	Zip Code	100	. Citizen of What Co	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Director		DDELTON		2/9//	'	1/54	
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al al	edical	UNPENDED	AMENDED				23d. Date of deliv	ven/
68760, certificate be nding physic se as the bur	. ₹	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr	nancy ₂ Fetal de	ath 3 Ectopic pre	gnancy	Month	Day Year
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of Vital Records, ng Physician: The law requir Met this certificate has been s meral director, page 2 should t	o Be		Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: Nu	ırsing Home 5	Residence 6 O	her:
		27. Manner of Death	28a. Date of Injury (Month, Day Year) Sep 7, 2009	28b. Time of Injury 1140 hrs	28c. Injury at Work?		now injury occurred struck by a truck	
ttendi death. ctor: y the f	atio	1 Natural 5 Pending 2 ✓ Accident Investigat	tion		1 Yes 2 ✔ No			
Division spital or Attendiours after death. eral Director: Affilled in by the fi	Certification	3 Suicide 6 Could not determine		ome, farm, street, fac	tory, office building, etc.	or Town, S		Rural Route Number, City
Di To the Hospital within 24 hours a To the Funeral I		4 Homicide 29a. Certifier A Continue Physics	cian: To the best of my knowled	ge, death occurred a	the time, date and place.			
To the I within 2. To the F	Medical	one) 2 ✓ Medical Examine	er:On the basis of examination a and manner stated.	ind/or investigation, i	my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
₽ ≥ ₽ 8	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (_
		hy ho, i	~ (,)		O.C.M.E.		September 8,	2009
		30. Name and address of person who			altimore, MD 21201			
	tate		Medical Examiner 111 32. Registrar's Signatu					
Regis		2 1.100	2009 Cenera	d. San	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Public 25 200 WRITIS 907PM 4c. County of Death Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death hestertown VER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June 14 1916 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 93 Months Days Hours Min. Maryland 1 □ M 2 🕅 F 216-42-6294 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 1 ☐Yes 2X No MD Kent Worton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21678 26665 Big Woods Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: White 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Elizabeth Turner George Austin Hurtt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Worton, MD. 21678 Samuel Clyde Morris (son) 26665 Big Woods Rd. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crumpton Cemetery 9/29/09 Crumpton, MD. 4 Donation 5 Dother (Specify) Signature of Funeral Service onsee 22. Name and Address of Facility Galena Funeral Home of Stephen 118 West Cross St. Galena, MD. Stephen L Schaech ena, MD. 21635 M00510 Approximate Interval Between Onset and Death Ratt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ca (Final disease or cardition resulting in death) ENAL Due to (or as a consequence of) NTEROBACTE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LIEART 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown EMENT 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) L⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-transit attending physician and for use as the burial-trar Box 68760, P.O. signed by the a d be detached f Records, cate has been signated by page 2 should b Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Physician/Medical

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Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, II w Medical Expriser could be notified as once.

Physician

/Medical

Examiner

altimore, Maryland 21215-0036

Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Certification: 1. Natural 5 Pending

2 Accident

4 Homicide

3 Suicide

29a. Certifier

investigation

28a. Date of Injury (Month, Day, Year) 6 Could not be determined

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

STREET, CHESTERTOWN,

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BROWN

SAYA A 31. Date filed (Month, Day, Year)

100 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 9 0715AM Stephen T. Michaels, Sr. 20 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WMHS-Braddock Campus Cumberland Allegan If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director 215-36-8776 November 11, 1940 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Modical Examples or mail be modified at 1 ☐ Yes 2 No Director Maryland Allegany Frostburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16601 Casino Drive SW U.S.A. Funeral 21532death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. Black, White, etc. 1 NYes 2 No 1961 If Yes, Give Year or Dates: 1967 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 1967 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Tire Division tire manufacturer s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence H. Michaels Kathryn Solomon other traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Michaels 16601 Casino Drive SW **Frostburg** Maryland 21532permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Porter Cemetery September 23, 2009 **Eckhart** Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami burial-trar The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IE EEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probabl ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an minom autopsy performed? this certificate europa+ 1 ☐ Yes 2 🗆 No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28c. 28d. Describe how injury occurred **≯** Matural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

19+

no

umberland mb 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAUROMatis

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate	e of Death	Reg. No.	1 1100			
Physici edical Exami		r Rondell Matthews September 9, 2009						
		Facility Name (if not institution, give street and number) 11600 White House Road	4b. City, Town, or Location of Deatl Upper Marlboro	4c. County of Death Prince George	's			
Funeral Director			yrs. If Under 1 Year If Under 24Hrs Months Days Hours Mir	⊣ ` 1 ∧	untry)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mertal Hyggene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 13816 Carlene Dr. 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 0r. Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 0 17. Father's Name (First, Middle, Last) Wendell Matthews 19a. Informant's Name/Relationship (Type, Print) Yvonne Matthews (Mother) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Marlboro 10f. Zip Code 20772	work done ired) White, etc. Specify: B1 Work done ired) White, etc. Specify: B1 16b. Kind of Business/I Prince Ge Board of e (First, Middle, Maiden Surname) e Crowner Rural Route Number, City or Town, State Upper Marlboro, Date 20c. Location - City or -15-09 Clinton, ns Mortuary, P.A	can Indian, Black, ack ndustry orge's Co. Education .Zip Code) Md. 20772 Town, State Md.			
Physician /Medical	/Medical Examiner							
of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate by After this certificate has been signed by the attending physic neeral director, page 2 should be detached for use as the bur	Completed by Physician	past 12 months? 1		23e. Did tobacco use contribute to 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes Yes	the cause of death? ably 4 Unknown topsy findings available ompletion of cause of			
Division of Vital To the Hospital or Attending Physician within 24 hours after death. To the Funeral Director: After this certi completely filled in by the funeral director	Medical Certification: To Be	examiner? 1	se of Injury 28c. Injury at Work? 1 Yes 2 ✓ No 28c. Injury at Work? 1 Yes 2 ✓ No 29c. License number O.C.M.E.	ang Home 5 Residence 6 ✓ Other 28d. Describe how injury occurred Ejected driver in automobile ro 28f. Location (Street and Number or Ru or Town, State) 11600 White House Road, Upper Module to the cause(s) and manner as state at the time, date and place, and due to the September 9, 20	ral Route Number, City Marlboro, MD ad. a cause(s) ath, Day, Year)			
St Regist	ate trar	31. Date filed (Month, Day Xear) 32. Registrar's Signature	enn Street, Baltimore, MD 2120	01				
OHMH 17 Rev 1/20	001	ORIG						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Grace Willie Macey 13, 2009 10:20 A M Sept. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Crofton Care & Rehabilitation Center Anne Arundel crofton If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 □ M 2 🖫 F 220-30-0062 84 Sept. 29,1924 Tennessee Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Crofton Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21114 2131 Davidsonville Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🛱 No White Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Home** Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Annie Laurie Helton Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23 Chestnut Hill Avenue Severna Park, MD 21146 McArthur Macey / Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Glen Haven Menorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Park ²². Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Signature of Funeral Service Licenses 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of Immediate Cause (Final disease condition result in death) e to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for an a nonsequence off: resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? rt I. 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to med examiner? 1 ☐ Yes 2 🔼 🗘 o 27. Manner of Death

Physician /Medical **Examiner**

and

Box 68760,

P.O.

Division of Vita Records,

Department of Health a Important: If item 27 Is any Injury or other trau

Pages 1

Physician

/Medical

Examiner

Director

Funeral

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Completed

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show

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Event interinal to mainfill of

Hygiene.

alth and Mental Hv

72 hours after death with

Baltimore, Maryland 21215-0036

Examiner Physician/Medical IF FEMALE: Š

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Certification: To

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1 Natural

2 Accident 3 🗌 Suicide

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requires that the death certificate be executed burial-transit attending physician for use as the burial signed by the a d be detached for should I he law cate has certificate After this Hospital or Attending s after dea. completely filled in by To the Hospital within 24 hours a To the Funeral C

9 Unknown	a D OUKHOWII
art II. Other significant co	onditions contributing to death but not resulting in the underlying cause given in Par

cal	26. Place of Death (Check only one)							
	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)				
ding stigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
ild not be ermined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				

29a. Certifier	1 Certifying Physi	cian: To the best of my knowledge, death occu	urred at the time, date and place	and due to the	ne cause(s) and manner as stated.					
(Check only	Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause									
one)	one) and manner stated.									
29b. Signature and	d title of Deralier		29c. License number	-	29d. Date signed (Month, Day, Year)					

State

se of death (Item 23a) (Type, Print) person who completed ca

D38958 9/14/09 Hughway Sw Glan Burne MD2106/

Registrar

			1 - For State Amend #8,	9-29-09, pe	Marylan r FHD I	R, HCHI	rtment of H	ealth and l Death	Mental Hyg R	eg. No.	9 3 6 9 4
	Physici /Medic		1. Decedent's Name (First, Mi	Asomal	MAG	CLAN	3		2. Date of Deat Month	Day Yea	212 1
mary.	Examir		4a. Facility Name (If not institu	ution, give street and number	er)		4b. City, Town, or	Location of Death	1	4c. County of De	
April 2			Montgomery Ge				Olney	KII-day 04 Ura		Montgome	
	Funeral Director		5. Social Security Number 212–11–1552	1 XM 2□ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	1933 Phi	Birthplace (State or Foreign Country) Llippines
	show show	or	Usual Residence of Decedent 10a. State 10b. Cou	inty		ty, Town or Lo	cation		Aug.21,	1933	10d. Inside City Limits 1X Yes 2 □ No
	the M	ect	MD Mont 10e. Street and Number	gomery	Rocl	kville	10f. Zip Code		1	0g. Citizen of What	
	th with 23a or	Funeral Director	14635 Bauer I	Orive #203			20853			JSA	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical EvanTher rust be notified at		11. Marital Status 1 ☐ Never Married 2 💢 № 3 ☐ Widowed 4 ☐ Divord	If Yes Give	s? X No		Was Decedent of His fYes, specify Cubar 1 □Yes 2 🌠 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, WI	merican Indian, hite, etc. ilipino
21215-0036	n 72 ho "natul	oletec	(Specify only hig	dent's Education ghest grade completed)		1 (Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of wor		16b. Kind of Busines	ss/Industry
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Maryland	2 should be filed w n and Mental Hygie Is marked other t raumatic event, In	Be	17. Father's Name (First, Midd Isaias P. Mad						ne <i>(First, Middle, I</i> a Luartes		
Ž	thould nd Me mark matic	은	19a. Informant's Name/Relati	-		19h Mailir	ng Address (Street a			r, City or Town, State	e. Zip Code)
Ma	nd 2 s lith ar 27 is r trau		Irene M. Wals							lle, MD 20	
Baltimore,	e = 1 %		20a. Method of Disposition	on 3 Removal from Sta		Place of Dispo cemetery, crer	sition (Name of natory or other place	∍)	Date	20c. Location - City	or Town, State
Baltii	permit. Pag Departmen Important: any Injury once.		21. Signature of Funeral Serv			Œ	- Singanomes	*CFematio	on Servi	ce P.O. I	
			23a. art 1. Enter the isease	e, or complications that cause	MO1:						Approximate
	Physician /Medical		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only one cause on each	as a conseq	e Pul	Mowary	fusi	2120		Interval Between Onset and Death
, ,	icate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	as a conseq	,				_	
68760,	cate be physicia the bur	edical		d			• •				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birt 4 ☐ Pregnar 9 ☐ Unknow	h 2 ☐ Feta nt at time of d	al death 3[☐ Ectopic pregnancy ☐ Other <i>(specify)</i>			23d. Date of Month	delivery Day Ye ar
rds, P.	puires that n signed b ild be deta	þ	Part II. Other significant con-	/	h but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown
of Vital Records,	: The law require cate has been sig page 2 should b	Completed	D'abetes	Acteur Do	Seas				24a. Was a autops perform	sy prior med? death	autopsy findings available to completion of cause of 1? fes 2 \sum No
ta		Be C	25. Was case referred to med		2 4 (1)			26. Place of Dea	1 □ Yes ath (Check only on		65 2 110
f V	Physici this cer al direct	10 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	atient 2 🖼	ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nursing H	lome 5 ☐ Resid	ence 6 Other (S	Specify)
	ding Pt h. After tt funeral		27. Manner of Death 1-BNatural 5 ☐ Per	28a. Date of (Month,	Injury <i>Day, Year)</i>	28b. Time o Injury	f 28c. Injury Work	/ at ?	28d. Describe h	ow injury occurred	
Division	Pr:	Certification:	2 Accident inv	estigation uld not be termined 28e. Place of	Injury - At ho	ome, farm, str fy)	M 1 □Y eet, factory, office	∕es 2□No	28f. Location (S City or Town	treet and Number or n, State)	r Rural Route Number,
_	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by ti	Medical C	29a. Certifier 1 Certifier (Check only one) 1 Medi	i ifying Physiclan: To the be ical Examiner: On the bas and manner	is of examina	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occi	e, and due to the durred at the time, d	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of cer				29c. License	number	2	29d. Date signed (Me	onth, Day, Year)
			> Joseph	# 15 All N	17		Ds	5317	5	Septembe	R162009
	ons.		,	Sall 16220	fred	erick	Print) Ruad #2	13 6AF	thersbu	y MD Z	,0877
-	Sta Registi	- 1	31. Date filed (Month, Day Ye	18 2009 32. BA	istrar's Signa	A. L	barker			1	

		For State Registrar		State of Ma	ırylanı		artment of <i>rtificate o</i> i			/lental Hy	/giene Reg. No		9 01695
Physici /Medic		1. Decedent's Name ((First, Middle, Las	MAN	MA	RK	OWIT	Z		2. Date of Do Month SEPIEI	De	19, Žear	3. Time of Death 9:07AM
Examir Funeral Director		4a. Facility Name (If r. Hebrew H 5. Social Security Num 167–18–19	ome of G	reater Was		ton ast birthday) Yrs.		kvil.	1e der 24 Hrs.	8. Date of Bi (Month, D March	rth lay, Year,	Montg 9. B 1922	
yland now		Usual Residence of D 10a. State	ecedent 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits
he Mar 28a-f sh ptiffad	Director		Montgome	ry	R	lockvi					10a C	itizen of What C	1 1√2 Yes 2 □ No
h with t	af Dir	10e. Street and Numb		ad			10f. Zip Code 20852				rog. O		U.S.A.
s after deat ", or Items?	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	d 2 Married	12. Was Decedent E Armed Forces? 1 ☐Yes 2 ☐ N If Yes, Give Year or Dates:	ever in U.S U.F lo		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔀 N	f Hispanic ıban, Mex		pecify Yes or N Rican, etc.)	0-	14. Race - An Black, Wh Specify:	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it is invited Eventual interpretational and once.	Completed k	1	5. Decedent's Ed y o <i>nly high</i> est gra	ucation	+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e durina r	most of work	king	16b. F	Kind of Busines	White s/Industry
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ING I	1	19a. Informant's Nam Janna Lyn	, -	<i>Type. Print)</i> 1, Daughte1	r /	1	ng Address <i>(Stre</i> Upton St				-		, Zip Code) 1850–1838
Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Dispo	sition	Removal from State			osition (Name of matory or other p			Date		_ocation - City o	
nit. Pag artmeni ortant: injury e		4 Donation 5	Other (Specifi	<i>(</i>)	Sh	alom 1	Memoria1 2. Name and Ado	Pk. Iress of Fa	9/21/	/2009 ard Sag	Phi	ladelph	ia, PA Direction,
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ding Physician: The law re h. h. After this certificate has bee funeal director, page 2 sho	e Completed	25. Was case referre	d to medical					00. 5	No. of Dass	24a. Wa aut per 1 □Yes th <i>(Check only</i>	opsy formed? 2 2 N	prior t death	
hysicia this cer	To B	examiner? 1 ☐ Yes 2 ☐	,			<u>:</u>	nt 3 🗆 DOA	Other: 4				6 ☐ Other (S)	pecify)
ding Phys th. : After this funeral di	tion:	27. Manner of Death 1 □ Natural 2 □ Accident	5 Pending investigation	28a. Date of Inju (Month, Day	ry v, Year)	28b. Time of Injury	W	juryat ork? ∐Yes 2	2 □ No	28d. Describe	how inj	ury occurred	
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: Completely filled in by the the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	iry - At ho c. (Specify	me, farm, st	reet, factory, offic	е		28f. Location City or To			Rural Route Number,
Hospi 24 hour Funer etely fill	Medical			ysician: To the best on niner: On the basis of and manner sta	f examina								
To the To the To the Comple	Med	29b. Signature and the	le of certifier			4.D.	29c. Lice	nse numb	er 430	6	29d. D	Pate signed (Mo	inth, Day, Year) FR 19, 2009
		30. Name and address	ss of person who	completed cause of b	eath (Item	23a) (Type	Print	ERO	4D, A	DOCK	111	LE, H	nth, Day, Year) FR 19, 2009 1D 20852
Sta		31. Date filed (Month)	, Day, Year)	32 Registra	ar's Signat	ture			-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 15,2009 3:05% Walter Morrisey 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Bradford Oaks Nursing Home Clinton Georges Prince Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 6. Sex Months Days Hours 1 🕅 M 2 🗆 F 245-50-5620 76 Dec.28,1932 NC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No PG Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7520 Surratts Road 20735 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify: Specify: 3 ₩ Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fairfax County School <u>Supervisor</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter L. Morrisey Mattie M. Faison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7017 Hastings Drive Capitol Heights, MD Betty Davis/sister 20743 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 9/23/09

Physicia /Medic Examine

Physician

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if than "natural", or items 23a or 28a-f show

item 27 is marked othe other traumatic event,

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurrial-transit

Division of Vital Records, P.O. Box 68760,

	- 1					, ,	23/02		14110	
ej l		21. Signature of Funeral Service Licer	nsee	22. Name a	nd Address of Facil	ity Hodo	ges & Edv	wards	F.H.	
once.		Joanna	Hodger				Rd., Sui			2074
n		23a. Par 1. Inter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	policitions that all ed the death. It one cause a chiling. a. Due to (or as a consequent)	Cance	_	s cardiac or re	espiratory arrest,		Approxin Interval E Onset ar	nate Between nd Death
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١.	2	Part II. Other significant conditions of	contributing to death but not resulting	ng in the underlying o	cause given in Part	l. 	23e. Did tobacco us 1 ☐ Yes 2 D		the cause of robably 4	
	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ o	24b. Were at prior to death?	completion of	gs available of cause of
	Re	25. Was case referred to medical examiner?			26. Plac	e of Death (C	heck only one)			
	0	1 ☐ Yes 2NDANO	Hospital: 1 ☐ Inpatient 2 ☐ ER	R/Outpatient 3 □ D	OA Other: 4 💋 N	lursing Home	5 ☐ Residence 6	i	cify)	
	ation:	27. Manner of D ath 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) n	Bb. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □	28d	. Describe how injury			
3	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		e, farm, street, factor	y, office	28f.	Location (Street and City or Town, State)	d Number or R	ural Route N	umber,
	Medical	29a. Certifler (Check only one) Certiflying Pl 2 Medical Example	hysician: To the best of my knowle mmer: On the basis of examination and manner stated.	edge, death occurred n and/or investigation	d at the time, date a n, in my opinion, de	and place, and eath occurred	due to the cause(s) at the time, date and	and manner a place, and due	s stated. e to the caus	ie(s)
:	Me	29b. Signature and title of certifier	Denog		c. License number	06		e signed (Mont		
		30. Name and address of person who William 1.	completed cause of death (Item 23	3a) (Type, Print) 11701 Live	zeh Ro	od Fr	2+WASNIN	ster. a	my/	ind.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year SEP 2 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Da Month Year Orozco Mariela 0526 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 💢 F Months Days 60 565-27-3399 Feb.10,1949 Colombia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 X Yes 2 □ No Alexandria 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5033 Murtha Street 22304 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No Specify: Colombian Specify: Hispanic 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) U.S. Government Foreign Service Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carlos Alberto Calderon Maria Cleofe Ortiz de Calderon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4486 Oakdale Crescent Ct., Fairfax, VA 22030 Mario Orozco/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Fairfax Memorial Funeral Home 20c. Location - City or Town, State 20a. Method of Disposition September | September | Pairfax, VA | Saddress of Facility Fairfax | September | Fairfax, VA | September | Fairfax, VA | September | Fairfax, VA | September | Fairfax, VA | September | Fairfax, VA | September | September | Fairfax, VA | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September | September 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and A Home, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to 6 as a consequence of) disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 Yes 2 No Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes

Physician /Medical **Examiner**

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Certification:

Medical

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

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Funeral

Director

28a-f show

items 23a or 28a-f sho her must be notified at

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al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked oth any jury or other traumatic event, once.

event, the Medical Examiner

filed within 72 hours after

altimore, Maryland 21215-0036

Director

by Funeral

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examiner resulting in death) Last Physician/Medical

29a. Certifier

one)

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

2 XN0

1 ☐ Yes 2 ☐ No.

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

28a. Date of Injury 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident Injury 3 Suicide 6 Could not be

and manner stated

1 🗌 Yes 2 TNo

1 Scriffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

RES-000

29d. Date signed (Month, Day, Year) 2009 eptenber

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

determined

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AVEND#24a/boerMD.9-25-09, HWW, MbCb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death September 15, Year 09 **Physician** Robinson Cardona Ordonez 7:10 pM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Fort Washington Hospital Fort Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 23, 9. Birthplace (State or Foreign **Funeral** . ^{Yea()}958 1**ॅ**M 2□ F Months Days Hours Min Colombia 214-83-1696 51 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or items 23a or 28a-f show Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12612 Holdridge Road 20906 USA or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☑Yes 2 □ No Specify: Colombian White event, the Medical Exaþ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed wit treent of Health and Mental Hygien tant: If Item 27 is marked other th jury or other traumatic event, Ital Master Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerardo Antonio Cardona Ana Ordonez 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Alarcon/Wife 12612 Holdridge Rd., Silver Spring, MD 20906 Department of Health Important: If Item 27 any Injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 d Cremation 3 ☐ Removal from State Sept. 2009 20 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Francis Adress Cornins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be execute burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à sign 2 No Completed 1 ☐ Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 1 ☐Yes 2 XNo Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director; / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 21 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

117-11

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year,

	1 - For State Registrar		•	rtment of tificate of			Reg. No.		3:59
Physician /Medical	1. Decedent's Name (First, Middle, VERNICE	Last)	PEARO	CE		2. Date of De Month	eath Day 1 <i>15 EVS 18</i>	Year	3. Time of Death 5.34 M
Examiner uneral rector	4a. Facility Name (If not institution, DOCTORS COMMU 5. Social Security Number 6 240 11 7706 Usual Residence of Decedent	NITY HOSPIT	AL vrs. last birthday) 49 Yrs.			8. Date of Bir	Prin		eorge lace (State or Foreign try) ington D
any injury or other traumatic event, the Modical Examiner rate be notified at once. To Be Completed by Funeral Director	10a. State 10b. County		City, Town or Lo					11	0d. Inside City Limits
inermust be notified Funeral Director	10e. Street and Number 2226 Alice A	venue #302		10f. Zip Code 2.07	45		10g. Citizen o	of What Coun	•
by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? d 1 Yes 25 No If Yes, Give Year or Dates:		Vas Decedent of fYes, specify Cu I □Yes 2 ☑ No	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	D- 14. R	Race - Americ Black, White, ϵ cify: $B1\epsilon$	an Indian, etc.
Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give life. L	dent's Usual Occi kind of work don OO NOT use retir	e during most of wor ed)	king		Busin <i>e</i> ss/Ind	,
To Be C	17. Father's Name (First, Middle, La Frank Gree	n			18. Mother's Nar	Ke1	, Maiden Surn $1{ m y}$	ame)	
אַ עו טוויפו ווימאוי	19a. Informant's Name/Relationship Lincreitia Lee 20a. Method of Disposition 1□Burial 2 ③Cremation 3 4□Donation 5□Other (Spe	daughter One of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	ľ	Alice sition (Name of natory or other pl			xon Hi	i 1 1 Me	d 20745 wn, State
any injui	21. Signatur Funeral Service Lie		22	. Name and Add	ress of Facility H	ALL BR			ERAL HOM
as the burial-transit and last leading ledical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.Cardio re Due to (or as a con- b. Sepsis Due to (or as a con- c. Pancreati Due to (or as a con-	sequence of):		Ларяє				Approximate Interval Between Onset and Death
Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnal	ncy			Date of delive	ery Day Year
6 6	Part II. Other significant condition	s contributing to death but not	resulting in the ur	nderlying cause g	iven in Part I.				ne cause of death? pably 4 🛣 Unknow
ral director, page 2 should: To Be Completed	25. Was case referred to medical				26. Place of De	1 □ Yes	opsy ormed? 2 🙀 No	b. Were auto prior to co death? 1 □ Yes	psy findings availabl mpletion of cause of 2 kg
E 5	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigar	28a. Date of Injury (Month, Day, Yea	2 ER/Outpatier 28b. Time of Injury	28c. In	ther: 4 🗌 Nursing I	lome 5 ☐ Res			(y)
ē 17	3 ☐ Suicide 6 ☐ Could no	ad 28e. Place of Injury - A	At home, farm, str	eet, factory, office		28f. Location City or To	(Street and Nu wn, State)	mber or Rura	al Route Number,
illed in by the funera Certification:	4 ☐ Homicide determin	building, etc. (3p							
completely filled in by the fu Medical Certification	4 Homicide determin	Physician: To the best of my xaminer: On the basis of examiner stated.	knowledge, deat	n occurred at the	time, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) and , date and place 29d. Date sig	ce, and due to	o the cause(s)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2009 1:10 P M Linda A. Rehrig Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Citizens Care and Rehabilitation Center Frederick If Under 24 Hrs. Hours Min. Social Security Numbe If Under 1 Year 8. Date of Birth (Month, Day, Yea February 21 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 60 Months Days Country)
Maryland 454-23-7324 1949 Director Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location notified at Director 28a-f 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral 21702 2090 Old Farm Drive, Suite 1E United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Unknown Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kenneth Rehrig Ruth Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090 Old Farm Drive, Suite 1E, Frederick, Maryland 21702 Dawn Ann Bambrick / Social Worker 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 26. 1 Burial 2 X Cremation 3 Removal from State 2009 4 Donation 5 Other (Specify) South Carroll Crematory Winfield, Maryland 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, 21. Signature of Funeral Vivinio M01433 Maryland 21701 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between n-et and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of: Wal decubitus ulaw Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami been signed by the attending physician and should be detached for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced demendia 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes After this certificate has been funeral director, page 2 shoult sundrene . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 24 hours after deat Funeral Director; 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Sigr 00062223 ss of person who completed cause of death (Item 23a) (Type, Print) J DLIVE FRENEMCE, 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{V9_t}27-2009 9:50 Ам Marceline C. Rice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Braddock Heights Vindobona Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours 1^M275-14929 1 M 2 X 80 218-24-1580 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Frederick Braddock Heights 1 🗌 Yes 2 🔀 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21703 USA 6102 Jefferson Blvd 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Susan Summers Raymond Hildebrand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Knoll Side Lane Middletown, MD 21769 Debbie Griffith Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 10-1-2009 Frederick, Maryland 4 Donation 5 Other (Specify) Mount Olivet Cem. 21. Signature of Fungral Service Lice 22. Name and Address of Facility Keeney & Basford P.A.F.H. 106 East CHurch Street Frederick, MD 21701 M01176 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10873 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? this certificate has ral director, page 2: 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Natural 28c. Injury at work? 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral C To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number D4/160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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State Registrar MAN-HING

31. Date filed (Month, Day, Year)

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M.D

32. Registar's Signature

		State Registrar Decedent's Name (First, Middle, L	ast)	C	ertificate	e of L	<i>Death</i>	2. Date of Death	g. No.	Voor	3. Time o	f Death
Physici /Medic Examir	cal	4a. Facility Name (If not institution, g					Location of Death	SEPTEMBE		2009 Inty of Death CECII	7:15	A M
Funeral Director		1 HIGHLANDS HI 5. Social Security Number 122–34–7787 6.		e (In yrs. last birthd 66 Yrs	ay) If Under		DEPOSIT If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day, AUG 05,	^Y 1943	9. Birth	place (State	
	tor	Usual Residence of Decedent 10a. State 10b. County	ECIL	10c. City, Town or		ORT	DEPOSIT			1	l0d. Inside C	City Limits
with the Ma 3a or 28a-f	Il Director	10e. Street and Number 1 HIGHLAND	S HILL		10f. Zip	Code	21904	10	0	of What Cour	-	
be filed within 72 hours after death with the Maryland rital Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Madical Evals fine files to notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X I If Yes, Give Year or Dates:		3. Was Deced If Yes, spec 1 ☐ Yes 2		ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	E			AN
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permit. Pages 1 a Department of He Important: If item any Injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control	☐ Removal from State	20b. Place of Dicemetery, R.A. FER				Date 21/09		on - City or To		PA
permit. Depart Import any inj	L	21. Signature of Funeral Service Lic	str-color	man		SCOI EWIS	T FUNERA STREET,	L HOME, I		CE, MD	21078	
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ly one cause on , ach li	a consequence of):				onary c		ase	Approxima Interval Be Onset and	tween Death
tificate be executed g physician and as the burial-transit	Medical Exar	that initiated events resulting in death) Last	c. Due to live as	a consequence of):	011							
as as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 Ectopic p 5 Other (sp		у	- in	23d.	. Date of deliv	very Day	Year
quires that t	þ	Part II. Other significant conditions	s contributing to death b	out not resulting in th	e underlying c	ause giv	en in Part I.		pacco use d	contribute to		death?
Physician: The law requires that the death ce this certificate has been signed by the attendi	Completed			· · · · · · · · · · · · · · · · · · ·				24a. Was a autops perforr 1 □ Yes	med?//	4b. Were aut prior to co death? 1 ∐Yes	opsy findingsompletion of	s available cause of
ysician: Th iis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ☐ ER/Outpa	atient 3 🗆 DC	Oth	or:	ath (Check only on	e)	Other (Spec	ify)	
ing	I ⊢ .	27. Manner of Death Natural 5 Pending investigat	28a. Date of Inju (Month, Da			28c. Injur Worl		28d. Describe ho				
	Certification:	3 Suicide 6 Could not determine	t be ed 28e. Place of In building, et	ury - At home, farm c. <i>(Specify)</i>	, street, factory	y, office		28f. Location (St City or Town	reet and No n, State)	umber or Rui	ral Route Nu	mber,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical		Physician: To the best caminer: On the basis of and manner st	of examination and/				urred at the time, d	ate and pla	ace, and due	to the cause	(S)
To the virthing of the the the the the the the the the the	Σ	29b. Signature and title of certifier	Lee MI	>	290	c. Licens	20 6	61 3	9d. Date si	igned (Month	, Day, Year)	
		30. Name and address of person when the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	12 1619	Revoli	pe, Print)	5	t. Havi	nede e	Trac	e M	02	10%
Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 1 2009	32. Registr	rar's Signature			,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ZABETH KITCHE LOUDINE /Medical Facility Name (If not institution, give street and number) of Death Town, or Location of Death 4c. County Examiner If Under 1 Year | If Under 24 Hrs. 26 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 😿 F 211-36-3922 Yrs 1923 Director 6-19-Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show the Medical Examiner must be notified at PA HUNDMAN BEDFORD 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15545 USA 152 BEDFORD Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evantine and. 1 XYes 2 No If Yes, Give Year or Dates: 44 - 46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No <u>۾</u> Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Elementary/Secondary (0-12) College (1-4or 5+) tome maker OWN 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (SR MILLER IULET 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 152 BEDFORD ST POBOX 655 HUNDMAN PA 15545 RITCHEY T. Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State HUNDMAN PA 9-7-09 HUNDMAN CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 169 Clarence st 21. Signature of Funeral Service License HUNDMAN PA 15545 HARVEY H. ZEIGLER F.H. INC 23a. Part 1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ruptured Abdominal aneuryism **Physician** /Medical Due to (or as a consequence of): Examiner Arteriosclerotic cardiovascular disease Sequentially not conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the burial by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 음 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary artery disease 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 1 □Yes 🗷 No 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: this 1 Inpatient ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral

5+

Medical

nds

Paul State

(Check only one)

and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 296 dicente gumber

29d. Date signed (Month, Day, Year)

Sept 4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Snow, M.D. Dpty med ex 123 W 3rd st Cumberland MD 21502

31. Date filed (Month, Day Year) 2009

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

		-	For State Registrer	State of Maryla		artment of H		Mental H	ygiene Reg. No.	09 31704
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last) MDLIN B.		157			2. Date of Month	Day 12	Year 3. Time of Death Year 001 M ty of Death
	Examin	er	4a. Facility Name (If not institution, give str 213 Hanover Stree	t	rs. last birthday)	4b. City, Town, or Ann If Under 1 Year	Location of Del napolis		Ann	ne Arundel 9. Birthplace (State or Foreign Country)
	Funeral Director		5. Social Security Number 229–56–7876 Usual Residence of Decedent	1 20 F 6		Months Days	Hours Mi		Day, Year) 7, 1941	Virginia
	Maryland	tor	10a. State 10b. County Maryland Anne Aru		City, Town or Lo		napolis	5		10d. Inside City Limits Mary es 2 □ No
	h with the 13a or 28a 11 be nut	Funeral Director	10e. Street and Number 213 Hanover Street			10f. Zip Code	21401			f What Country? J.S.A.
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene itam 27 Is marked othar than "natural", or Itams 23a or 28a-f show othar traumatic avant, I'm Medical Examinat number rediffied at	þ	11. Marital Status 12 Never Married 2 Married 3 ☑ Widowed 4 □ Divorced	. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXIvo	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No- 14. Ri Bl	ace - American Indian, lack, White, etc. city: White
21215-0036	within 72 ho ene. than "natura	Completed	15. Decedent's Educa (Specify only highest grade		life.	dent's Usual Occup a kind of work done DO NOT use retired Interior I	1)			Business/Industry Design
land 2	buld be filed within Mental Hygiene. arked othar than atic avant, II.A.Me	To Be Co	17. Father's Name (First, Middle, Last) Arnold Blaylock					Name (First, Mid Ina Pais	dle, Maiden Sum.	ате)
Maryland	1 and 2 should Health and Men Iam 27 Is marke		19a. Informant's Name/Relationship (Type Thomas Ripley/son	, Print)		ing Address (Street Melrose Av			s, Mary	
Baltimore,	0 0		20a. Method of Disposition 1 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	moval from State	cemetery, cre S. Nava	osition (Name of amatory or other place al Academy	y Cem.	9/25/20)9 Annar	n-City or Town, State
Balti	permit. Pag Department Important: I any injury o gnce.		21. Signature of uneral Service Licenses	Lit						Funeral Home polis, MD 21401
	Pnysician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the concause on each line. Due to (or as a con	Demet	iter the mode of dyir	ng, such as card	diac or respirato	y arrest,	Approximate Interval Between Onset and Death
	Examiner 5	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con						
,092	ite be executed ysician and ne burial-transit	cal Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):					
.O. Box 68	ne death certifica the attending ph hed for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pre 1 Live birth 2 II 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			Date of delivery Month Day Year
4	uires that the signed by Id be detac	by	Part II. Other significent conditions cont	ributing to death but not	t resulting in the	underlying cause gr	ven in Part I.		oid tobacco use c	contribute to the cause of death?
Records,		Completed						_	autopsy performed?	Were autopsy findings available prior to completion of cause of death? To Yes 2 No
Vital	siclan: certific rector,	Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpati	ent 3 DOA Ot		Death (Check o	nly one) Residence 6 □	Other (Specify)
of	ng Telling	atlon: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea		of 28c. Inju		28d. Desc	ibe how injury oc	curred
Division	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (St	pecify)			City o	r Iown, State)	umber or Rural Route Number,
	To the Hospital or within 24 hours afte To tha Funaral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Phys 2 Medical Exemin	ician: To the best of my er: On the basis of exa- and manner stated.	mination and/or	investigation, in my	opinion, death c	occurred at the t	me, date and plac	ce, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	Denta	1	29c. Licen	se number		29d. Date sig	gned (Month, Day, Year) runher (4, 2009 POCES MD NYU
J 4	117		30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person address of person and address of person address of person and address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person address of person a	Poted cause of death	(Item 23a) (Typ	B. Print)	IF H	76HWA	y ANNA	Pous Monyu
7	St Regist	ate	31. Date filed (Month, Day, Year) SEP 17 20	32. Registrar's S	Signature	bare				

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of Maryland		rtment of H tificate of I			iene _{eg. No.} 200	9 3 1 7 0 3
Physicia		1. Decedent's Name (First, Middle, Last)	Jesus Aqu	ino	Reyes		2. Date of Deat Sept.	^h 1 7 ^{рау} 2009 ^{еаг}	3. Time of Death 9:18а м
/Medic Examin		4a. Facility Name (If not institution, give str Washington Adve:	reet and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	rthplace (State or Foreign
Director stand works at all		Usual Residence of Decedent 10a. State 10b. County Md Prince G	eorge's A	Town or Loc delph	cation		0,007		10d. Inside City Limits 1 □ Yes 2 No
with the Na or 28a-	Direct	10e. Street and Number 1913 Lebanon S	treet		10f. Zip Code 20	783	1	Og. Citizen of What C	_
partitioner, Invary factor 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Mudical Examinar must be notified at once.	by Fu		2. Was Decedent Ever in U.S. Armed Forces? 1	1	Was Decedent of H fYes, specify Cuba	ispanic Origin? (Sp un, Mexican, Puerto Specify: Guatem		14. Race - An Black, Wh Specify: W	ite, etc.
ithin 72 horner. ne. han "natur?	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired memaker			16b. Kind of Busines Own Ho	-
dillo All dibe filed we antal Hygien ced other the	Be	17. Father's Name (First, Middle, Last) Jose Aquino		поі	Helliaket	18. Mother's Nam	e (First, Middle, I	Maiden Surname)	
Mary	2	19a. Informant's Name/Relationship (Type Olga Valle/Gran		19b. Mailir 903	ng Address <i>(Street</i> Venice	and Number or Rui	ral Route Numbe Silver	r, City or Town, State Spring, M	, Zip Code) d • 20904
Pages 1 an ent of Heal		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation / 5 ☐ Other (Specify)	20b. Pla	metery, crem te of	sition (Name of natory or other place Heaver	^(e) 9/28	/2009		Spring,Md.
permit. Pages Department of Important: If it any injury or o		21. Signature of pregal Service License	Di-	P#	Named Aprel Aprel 41 Colu	RINALDI mbia Bl	FUNER vd.Sil	AL SERVIO ver Spri	CE,P.A. ng,Md20910
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DOX O sath certifi attending for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	☐ Ectopic pregnan ☐ Other (specify)	су		23d. Date of o	delivery Day Year
cords, F.O. w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions con Diabetes type	-	Iting in the u	nderlying cause gi	ven in Part I.			to the cause of death? Probably 4 🛣 Unknown
The larate has	Completed						24a. Was autop perfo 1 □Yes	rmed? prior death	autopsy findings available to completion of cause of ? es 2 \Boxed No
VITAI rsician: T s certificat lirector, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	nt 3X DOA Ot	or:	th <i>(Check only o</i> lome 5 ☐ Resid	<i>ne)</i> dence 6 ☐ Other (S	(pecify)
VISION OT VITAI HO Attending Physician: The Indeath. Tracetor: After this certificate his by the funeral director, page	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 28c. Inju	ry at		now injury occurred	
DIVISION al or Attending s after death. Il Director: Afte	Sertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hobbiding, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (3 City or To	Street and Number or vn, State)	Rural Route Number,
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, dea tion and/or i	th occurred at the nvestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	date and place, and	due to the cause(s)
10 To within comp	Me	29b. Signature and title of certifler	no Me	9	29c. Licen	se number 19400		Sept. 21	,2009
		30. Name and address operson who co Ernesto Africa	mpleted cause of death (Item	3 4 4 U	niversi	ty Blvd	.W #211	Silver	20901 Spring,MD
St Regist	ate trar	31. Date filed (Month, Day, Year) SEP 21 2009	32. Registrar's Signat	ture	plad .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SHIPLEY Month **Physician** 10 200 /Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) **Examiner** OMBERLAND MEMORIA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (În yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 X F 218-50-2402 86 11-19-Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Exarciner must be notified at 1 ∐Yes 2 No BEDFORY JFFALO Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 USA Double Lane 142 items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ,o 1 ☐ Yes 2 🗷 No Specify: White If Yes, Give Year or Dates: ģ 3 M Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Ite Insulation Elementary/Secondary (0-12) College (1-4or 5+) Home ma Ker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET LOUISE WARE WALTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RONE Comberland MD 21502 BEDFORD TERRY MILLER DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Buffalo Mills MADLEY CEM 4 ☐ Donation 5 ☐ Other (Specify) HYNOMAN PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Harvey H. Zeigler F. H. Inc 15545 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final cu d **Physician** resulting in death) /Medical Due to (or an anonsequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Exami and P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 Fetal death 4 Pregnant at time of death Year Month Day signed by the at d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed?/ yes 2 No 2 No certificate 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

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nds

State

Registrar

900 SETON DP, CUMBERLAND MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

14 2009

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 2009 3:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10194 Shelldrake Circle Montgomery Damascus Social Security Number 6. Sex 1 🗶 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 12/30/197 **Director** Salvador 37 216**-41-**1879 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Marvland Montgomery Damascus 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10194 Shelldrake Circle 20872 El Salvador 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: E1 Salvadoran If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Landscaper Landscaping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jorge A. Salvador Maria C. Aquino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly K. Salvador/ Wife 10194 Shelldrake Circle, Damascus, MD 20872 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 9/15/09 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Mull 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Stomach Cancer months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day 2 No 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 💢 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 15/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Besta 9W 31. Date filed (Month SE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** SUTUR CHRISTABELLE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Arundel Anne Mandrin Chesapeake Hospice House Harwood Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 7 F 12/25/1932 Washington. Director 578-40-3790 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Eventral and 1 ∐Yes 2 👿 No Director Edgewater Marvland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21037 3232 Rolling Rd. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2**X** No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Saltimore, Maryland 21215-0036 Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) 12th College (1-4or 5+) Florist Owner permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christabelle M. Long George K. Mann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3232 Rolling Rd., Edgewater, Edward L. Sutor, III/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 9/17/09 Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) Hillcrest Cemetery 21. Signat of Funeral Service Cens 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) HUGIE 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation in records. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar MICHAEL.
31. Date filed (Month, Day, Year)

32. Registrar's Signature

Name and address of person who completed dause of death (Item 23a) (Type, Print)

SEP 17 2009

Lewa A. park

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State of Maryland / Department of Health and Mental Hygiene

		•	1 - For State Registrar Cel	rtificate of Death	Reg. No).
	Dhysisia	200	1. Decedent's Name (First, Middle, Last)		Date of Death Month Da	3. Time of Death 5:56 p M
	Physicia /Medic		Austin William Smith	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		14, 2009 5:56 P
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	Anne Arundel
			Baltimore Washington Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
	Funeral Director		420–34–4236 1⊠ M 2□ F 88 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 12,	1920 Country Alabama
	٠,		Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	aryla shov	'n	10a. State 10b. County 10c. City, Town or Lo MD Anne Arundel Severna	_		1 □Yes 2 XNo
	the M	Director	10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?
	I within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Extrail art must be trofffind at		442 Cloverdale Circle	21146		USA
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
õ	after or ite		1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	1 □Yes 2 No Specify:		Specify: White
9500-612	hours ural"	od be	3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW II ☐ 15. Decedent's Education ☐ 16a. Dece	dent's Usual Occupation	16b. l	Kind of Business/Industry
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N	d with giene er tha	튽	Direct	tor of Administrat		ansportation Authorit
D	be filed tal Hygi d other event, II	Be	17. Father's Name (First, Middle, Last) Walter Smith	18. Mother's Name	(First, Middle, Maide Gray	n Surname)
<u>\S</u>	should be and Mental s marked o umatic eve	은		ng Address (Street and Number or Rura		or Town State Zip Code)
<u>8</u>	SES		19a. Informant's Name/Relationship (Type. Print) Ester Smith/Wife 19b. Mailli 442	Cloverdale Circle	Severna	Park, MD 21146
ē,	iges 1 and 2 nt of Health at the 1 tree 27 is or other tree		20a. Method of Disposition 20b. Place of Dispo	psition (Name of matory or other place) Sept	Date 20c. I	ocation - City or Town, State
Baitimore, Maryland	Pages nent of int; If It				2009 Cr	rownsville, MD
<u>=</u>	permit. Page Department of Important; If any injury of once.		21. Signature of Euperal Service Licensee 22.	2. Name and Address of Facility	A Severr	na Park Funeral Home
<u> </u>	6 3 E 6 9		January 4	95 Gov. Ritchie Hw		na Park Funeral Home na Park, MD 21146
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause or each line.	1 1 1		Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	ic Heart Dise	() L	2067
	Examiner		vue to (or as a consequence of):	AMIC		1995
		ner	sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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68760	ertificate ing phys as the	Medical	d			
Box	eath certi attending for use a		IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery
	death	Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Other (specify)		Month Day Year
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<u>-</u>	nyslci nis cer direct	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 ☐ Other (Specify)
0	ng Pl	L:uo	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Work?	28d. Describe how inj	jury occurred
Sio	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury At home, farm, st	M 1 Yes 2 No	28f Location /Street	and Number or Rural Route Number,
Division of Vital Records,	or At after of Direct in by	Certification: To	4 Homicide determined building, etc. (Specify)	reet, lactory, office	City or Town, Sta	ate)
_	spital			th occurred at the time, date and place	, and due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.			
	Noth Your Corm	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Mpnth, Day, Year)
P			Cugue /home (am 10)	00036242		7/13/2001
7	41 CH	1	30. Name and address of person who completed cause of death (Item 23a) (Type Eugen & Thomas Manion MD, 137/	7 Fibells Chence Rd #1	80 Edean	Jes MD 21032
T,	Sta	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature		- 1 7 1 5	
	Regist		SEP 1 7 2009 Renova S.	Marke		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥬 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kyonq Hui Schrack 2TEMBER 16, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIE ANNE BACTIMORE WARHINGTON MEDICAL CENTE CHEN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 212-06-9230 **Director** S. Korea Mar 21, 1954 Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Examination must be notified once. 1 ☐ Yes 2 No Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 458 Old Quarterfield Road #E8 USA 21061 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building Maintenance Cleaning Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Han Kap Song Yi Sun Im ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith B. Schrack/husband 458 Old Quarterfield Rd. #E8 Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 09/18/09 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis at e, or complications that caused the shock, or heart fail line. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) VARAN CANCER **Physician** METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 M No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown g Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man or of Death 1 ✓ latural Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29d. Date signed (Month, Day, Year)

م م

State Registrar M.S.

D 45149

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gleu Burrie MJ 2016

31. Date filed (Month, Day, Year)

SEP 18 2009

SEP 18 2009

SEP 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 0009 09 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Days Months 01/04/1930 Illinois 79 365 28 8713 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2X No Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 1690 Coventry Place 12. Was Decedent Ever in U.S.
Armed Forces?
1 \(\omega \) Yes 2 \(\omega \) No
195
If Yes, Give
Year or Dates:
195 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1952-1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: 1953 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Financial/University Banker/Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Isaacs Robert Brian Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1690 Coventry P1/Annapolis MD 21401 Anne Carman/Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 9/15/09 Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Advent Funeral and Cremation Services 21. Signature of Funeral Service Licensee Med Glinawai Annapolis MD and Falls Church VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WEEK) DUB Dunn disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATI 1 ☐ Yes 2 No 3 Probably 4 Unknown OSTATE Bleid 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 Z No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 □ No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

/Medical Examiner be executed attending physician and for use as the burial-tran law requires that the death certificate the detached been signed by the should be detach funeral director, page 2 should has certificate

this

After t

filled in by the

ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t

within 2.

Box 68760.

P.O.

Division of Vital Records,

Physician

/Medical

Director

Funeral

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Completed

MD

Examiner

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be collified at

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or Iter

permit. Pages 1 and 2 s
Department of Health ar
Important: if Item 27 Is
any Injury or other trau

Physician

Baltimore, Maryland 21215-0036

death with

Examine Physician/Medical ੬ Completed

Be

Certification: To

Medical

State

Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐No 9 Unknown

5 Pending investigation

Date of Injury (Month, Day, Year) 28b. Time of 090409

28c. Injury at Work? UNKNUW

1 ☐ Yes 2 Z No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred AL BACKWANDS STEPS AT H FELL HomE

28f. Location (Street and Number or Rural Route Number, City or Town, State) 690 COUP NTOY PL MALIPU Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifie

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

and manner stated.

HOME

29c. License number

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) Name and address of person who completed MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

SEP 16

6 ☐ Could not be

determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 09 Month 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15 Day 2009 10:22 A M **Physician** Zadel Skolovsky /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 93 Yrs. 8. Date of Birth Birthplace (State or Foreign
Country) Social Security Number **Funeral** Months Days Hours Min. 07/17/1916 555-22-2652 1 M 2 F Canada Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a "Medica Exander traumatic event, it along the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the None 1x Yes 2 No Director New York NY 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 240 E. 79th Street #10A 10021 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔣 No Specify: ģ 3 Widowed 4X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Concert Pianist / Professor Music 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kate Jones Max Skolovsky ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michele J. Altemus/niece 9909 Ashburton Lane Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ARemoval from State Hillside Park 09/22/09 Los Angelos, CA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 21. Signature of Ineral Service License Approximate Interval Between emblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, of conshock, or heart failure. List only Onset and Death Immediate Cause (Final disease or condition resulting in death) scle rotic + rten'o Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the userul continuous to concern within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 10 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 ☑No 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier EMETGERCY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suburban Hospital

Registrar

State

Barton

31. Date filed (Month, Day, Year)

eonov

21

32 Registrar's Signature

8600 Old Georgetown Road Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Esther Mostow Savitz 7:00 A M 2009 Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F 91 Days Hours 290-42-5048 Yrs. Director 8, 1918 Ohio Aug. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exar uner must be notified at Yes 2 No Director MD Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 1799 East Jefferson Street #210 20852 USA items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married "natural", or Specify: White 1 ☐ Yes 2X No Specify. 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mertal Hygien. Important: If item 27 is marked other the any injury or other traumatic event, Ital. once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Mostow Ida Zaputa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12721 Split Creek Court N.Potomac, MD 20878 James E. Savitz / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/13/09 Beth Israel Cemetery Hamilton, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility dward Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licensee M01163 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the state, or complications that caused the death. Do not enter the mode of dying, such as cause shock, or heart failure. List only one cause on each line. or respiratory arrest. Onset and Death Immediate Cause (Final disease or condition resulting in death) MOOME **Physician** Subdural Hematoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi Due to (or as a consequence of) Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Fell while getting dishes 7:23 PM 09/01/09 1 ☐ Yes 2 ☑ No 2 X Accident investigation the at apartment 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural City or Town, State) 799 East Rockville, MD 20852 Jefferson 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760. filled in by completely

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP

21 2009

Mahan Hubby mo

29c. License number D62562

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

September 11, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rockville, MD 20850 9901 Medical Center Drive

Madhavi Hubbly MD

32. Registrar's Signature racks

Home-Assisted Living Facility

Please Type or Print in Black Indelible Ink/ Freurek All Copies Are Legible.
Amend Item 25 per phys.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 18 2009 Thomas Richard Shea /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WICOMICO ALISBURY Regiona L ENINSULA Medical Cento Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/22/1928 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) Days Hours tX□M 2□F 8 Ĭ Months 123-20-9467 USA NY Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD Berlin Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9 Beach Court 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1√Yes 2 No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2★☐No Specify. Specify:White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Inc. M. Elementary/Secondary (0-12) College (1-4or 5+) manager telephone co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cornelius Shea Rhoda McDonald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen C. Shea Beach Court Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Vet. Cem. 21. Signature di Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** OBSTRUCTIVE PULMONARY DISGASE fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed LUNG, CANCER and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 □ Yes 1 □ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0065972 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SN6+1

Division of Vital

State Registrar Dayed labatabai

31. Date filed (Month, Day, Year)

100 E. Carroll

32. Registrar's Signature

50, Baltimore, Maryland 21215-0036	be executed be executed be greatly and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Cian and Compared the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit on the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit on the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than "natural", or items 23a or 28a-f show purial-transit of the firem 27 is marked other than 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of the firem 27 is marked other purial-transit of t
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Physic /Medi Exami

Funeral Director

	1- State of Maryland / Department of Health ar Certificate of Death	nu went	Reg.		4.0	01110		
	1. Decedent's Name (First, Middle, Last)	2. Dat Mo	e of Death	Day	Year	3. Time of Death		
an cal	Shirley T. Tippett		ptembe			7:53 A M		
ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of I			4c. County				
	Baltimore-Washington Medical Center Glen Burnie			Anne	Arund	le1		
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4 Hrs. 8. Dat	e of Birth		9. Birthpla	ice (State or Foreign		
	218-14-1139 1 86 Yrs.	Min. 10,	e of Birth onth, Day, Ye 24/19	22	Mary]	and		
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				100	d. Inside City Limits		
to	Maryland Anne Arundel Annapolis					1 □Yes 2 No		
rec	10e. Street and Number 10f. Zip Code		10g.	Citizen of V	What Countr	y?		
al Di	609 Yawl Court 21409			US	A			
ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin Armed Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	in? (Specify Ye	s or No-		e - America			
Completed by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Specify Cuban, Mexican, F 1 Yes, Sive Year or Dates: 1 Yes, Specify:	Puerto Rican, o	etc.)	Specify	ck, White, et v: Wh	ite		
eted	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of life. DO NOT use retired)	of working	161	. Kind of Bu	usiness/Indu	stry		
dmo	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker				Home			
BeC	17. Father's Name (First, Middle, Last) 18. Mother's	's Name <i>(First,</i>	Middle, Mai					
일	Carlton E. Thorne	laude M	. Tay1	or				
-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of	or Rural Route	Number, C	ty or Town,	State, Zip (Code)		
	Elmer H. Tippett, Jr./ Son 609 Yawl Ct., Anna				. ,	ŕ		
-	20a. Method of Disposition 20b. Place of Disposition (Name of	Date			City or Tow	n, State		
	4 Donation 5 Other (Specify) Cedar Hill Cemetery 9				nd, MI			
	21. Signature of Funeral Service Densee 22. Name and Address of Facility 2973 Solomons I	_						
er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):							
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener unuerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.							
hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)				te of deliver onth E	y Day Year		
d by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23				cause of death?		
ete	Lypsotenier	_		1				
Comp		- _	a. Was an autopsy performed]Yes 2 €	12/	vvere autops prior to com death? 1 □Yes 2	sy findings available pletion of cause of		
Be	examiner	of Death (Chec	k only one)					
ပ္		sing Home 5	Residenc	e 6 □Oth	er (Specify)			
inol	27. Manner of Death 28a. Date of Injury 1 □ Natural 5 □ Pending (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		scribe how i	njury occur	red			
cati	2 Accident investigation M 1 Yes 2 No		_					
ertifi	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Stree y or Town, S		er or Rural	Route Number,		
Medical Certification: To Be	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	l place, and due n occurred at th	e to the caus ne time, date	e(s) and m and place,	anner as sta and due to	ated. he cause(s)		
Me	29b. Signature and title of certifier 29c. License number 29c. License number	4	29d.	Date signe	d (Month, D	ay, Year)		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ve 1	(E)	-32	Len	ham no		
te ar	31. Date filed (Month, Pay Year) 7 2009 32. Registrar's Signature				10	177		
	Comment la la la la la la la la la la la la la							

Sta Registr

State of Maryland / Department of Health and Mental Hygiene - State #7, per funeral home, D.H. Certificate of Death WCHD Amended item Date of Death
 Month Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 09 1214 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner icom q If Under Date of Birth (Month, Day, 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗖 F Months Days 84 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits State 10c. City, Town or Location "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examinar must be required and once. 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>Ş</u> 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1/*†*n 18. Mother's Name (First, Middle, Maiden Surname Be 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas eN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State empergreevil 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee HOM, C POBOX 278 Tem For pergnee ames 23a. - 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a rdiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) P.O. Box 68760. physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3

Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1) EMENT/A 2 🗌 No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 2 [] No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 🗆 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DH 5 614 B 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

09-07456 Debra Todd		Please Type of State of				Ensure All C ealth and Ment		egible	e.	0 01 == 1	
		- For State Registrar			icate of De			Reg. No.	200	9 3 1 7 1	
Physicia		1. Decedent's Name (First, Middle,Last)					Date of De Month	Day	Year	3. Time of Death 1941 hrs	
Medical Examin	(e)	Debra I 4a. Facility Name (if not institution, give		ndd	Tab C	ty, Town, or Location o	Septemb		2009 c. County of Death	19411115	
é		Easton Memorial Hospital	street and number)			ıston	Doddi	1	Talbot		
Funeral		5. Social Security Number 6. Sex	7. Age	e (în yrs. last	birthday) If	Under 1 Year If Under		Birth (MM	/DD/YYYY) 9. Birth		
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yland a-f sho	흱	Maryland Caroli 10e. Street and Number	ne		Denton	. Zip Code		10a. Cit	izen of What Coun		
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	8766 Mitchell Roa	7		1.50	21629		•	d States o		
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hours: hours		15. Decedent's Education (Specify onl Elementary/Secondary (0-12)	y highest grade com College (1-4 or 5			sual Occupation (Give k f working life. DO NOT		16b.	Kind of Business/Ir	dustry	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12 HS grad 1 17. Father's Name (First, Middle, Last)					s Name (First, Middle	, Maider		-	
121 be fill ental H	a	Wilfred	Alphons	e Pa	rentea	u	Marion	Lou	ise Ha	11	
D 2's should Mund Mund Mund Mund Mund Mund Mund Mun	۴	19a. Informant's Name/Relationship (Ty	Fath	er		ress (Street and Num					
i, MD and 2 sho ealth and lem 27 is traumati	ŀ	Wilfred A. Pare 20a. Method of Disposition	<u>enteau</u>	20b. Plac	8/66 M ce of Disposition	1tchell R (Name of cemetery,	load, <u>Der</u> Date	1ton 20c.	Location - City or	and 21629 Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3	Removal from Sta	are l	matory or other p	emetery	9/29/200	\ d	Denton	Maryland	
Iltim iit. Pa artmer ortani	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licens	ee			and Address of Facility					
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Physician		23a. Part I. Enter the disease, or complifailure. List only one cause on each	cations that caused	the death. Do	o not enter the m	ode of dying, such as ca	ardiac or respiratory	arrest, sh	ock, or heart	Approximate Interval Between Onset and	
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tal Records, P.O. Box 68760, ctan: The law requires that the death certificate be execut certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - tran	Physician/Medical	UNPENDED	AMENDED		. <u>-</u>						
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Boy death the attr	ıysi	1 Yes 2 No 9 V Unknown	9 Unknown		o otilei	(Op Cony)					
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Vital Rec ysician: The his certificate director, page	Be (25. Was case referred to medical examiner?	ospital:		7/2 / // / /	26.Place of Death	7	70-44	0 0		
of Vi ing Physi After this	٤	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	hannl	R/Outpatient 3		Nursing Home 5		lence 6 Other		
Division of Vital Records, tal or Attending Physician: The law requirers after cleath. al Director: After this certificate has been si led in by the funeral director, page 2 should be	ion	1 Natural 5 Pending	Sep 23, 2009		900 hrs	1 Yes 2 🗸	Driver aut		object collisio	n	
/iSic r Atte ter des irecto	fical	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of In	ijury - At hom	e, farm, street, fa	ctory, office building, et			and Number or Ru	ral Route Number, City	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Sal	Orieck drily				at the time, date and pla					
To th withir To th compl	Medical		on the basis of exait and manner stated.	minadon and/	or investigation,	in my opinion, death oc 29c. License number	corred at the time, da		. Date signed (Moi		
	2	230. Signature and title of certifier				O.C.M.E.			ptember 24, 2		
		30. Name and address of person who c	nmpleted cause of d	leath (Item 22	Ra)						
			Assistant Medic			enn Street, Baltime	ore, MD 21201				

DHMH 17 Rev 1/2001 O€ME 2006°,

Registrar

OCME

32. Registrar's Signature

State 31. Date filed (Month, Day, Year) SEP 2 5 2009

ORIGINAL

		1	For State Registrar	State	of Marylar		artment <i>tificate</i>			/lental Hy	giene 2 (09	31718
Physic	cian/ dica	'	Decedent's Name (First, Middle Grace Anna Veal							2. Date of De	ath Day Aber 2:	Year 2009	3. Time of Death 2340 M
Exam			a. Facility Name (if not institution, Memorial H	give street and nu	mber)			own, or Lo	cation of Death		4c. Count	y of Death	•
Funer Direct		L	Social Security Number 218–24–7223	6. Sex 1 ☐ M 2 🛛 F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July	th Y Y ^{ear)} 14 1933	9. Birthpl Countr Mary	ace (State or Foreign Land
with the Maryland s 23a or 28a-f show ust be notified at.	Piroctor	_ [Journal Residence of Decedent Oa. State 10b. County	ine	1	ity, Town or Lo	10f. Zip C	ode 21639)		10g. Citizen of	What Count	d. Inside City Limits 1 X Yes 2 No
ITE, INIAI YIAII U Z I Z I D-UOJO 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. of Health and Mental Hygiene. A stranger of the trans "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.	Completed by Eur	5	(Specify only higher Elementary/Seconday (0-12)	Armed F 1 ☐ Yes If Yes, G Year or E t's Education st grade completed	2 🕅 No ve pates.	16a. Deced	f Yes, specify Yes 2 Jent's Usual Chind of work of NOT use re	Cuban, N No S Occupation done during tired)	n ng most of work	Rican, etc.)	Specif 16b. Kind of B	Business Indi	ck ustry
yidilla Zida be filed with Mental Hygierarked other attice event, the	T G G		11 7. Father's Name (First, Middle, L John Murray	ast)		sear	ood p				Maiden Surnan		dustry
d 2 should alth and Malth and Mar 127 is mar or traumati		ľ	19a. Informant's Name/Relationsh Fred D. Veale/	ip (Type, Print) husband			ng Address (S		Number or Rura	al Route Numbe	er, City or Town,		ode)
dillillore, rmit. Page 1 an partment of He portant: If item		2	0a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		n State	Place of Dispo cemetery, cren kers Ce	sition (Name natory or oth	of er place)	9/30	Date / 09	20c. Location	•	n, State
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e be executed Exam Wedic Exam Assician and e burial-transit	al		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any least 19 heart of the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to	(or as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a consection as a conse	quence of):			_		vary [Approximate Interval Between Onset and Death
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an: The lav tificate has or, page 2	ه ا	2	5. Was case referred to medical					26. Place	of Death (Checi	1 🗌 Yes	psy ormed? 2 No	prior to com death? 1 Yes 2	pletion of cause of
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DIVIDION Attains after de ral Directe illed in by t			3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 28e. Plac build	e of Injury - At h ing, etc. (Specif	fy)				City or Tov			
o the Hosp vithin 24 ho o the Fune	Medical		(Check 2 Medical E	Physician: To the kaminer: On the ba Nurse Practioner	sis of examination	on and/or invest	tigation, in my death occurre	opinion, o	death occurred a ne, date and plac	t the time, date a	and place, and di	ue to the caus nanner as stat	se(s) and manner stated. ed.
		3	0. Name and address of person v	Le vho completed cau	se of death (Iter	m 23a) (Type, F	P		5311	0	epter		
	itate		Dennis M. DeSh	ields, M		9 S. Wa		ton S	treet;	Easton,	, MD 216	01	
Regis			1. Date filed (Month, Day, Year) SEP 25 20	19 /	A.	BONA							

DHMH 17 Rev 7/2009

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 11:45 AM Sept. 2009 RANSOME WYATT EVERETT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Old Federal Hill Road Jarrettsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 2/3/1928) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Year 1 X M 2 ☐ F Carolina 242-36-291 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 1 ☐ Yes 2X No Jarrettsville Harford MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21084 United States 3971 Old Federal Hill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Water Treatment Plant Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cordie Ashley Wyatt John Thurman Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) Jarrettsville, MD 3971 Old Federal Hill Rd. Ruby A. Wyatt (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baptist View Cem. 10/1/2009 Forest Hill, MD. 22. Name and Address of Facility E.G. Kurtz & Son Funeral 21. Signature of Funeral Since Ligen fee Home, P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of)

Physician /Medical Examiner amine

Physician

/Medical

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Funeral

Director

Ji Hygiene. other then "neturel", or Items 23e or 28e-f ehow vent, the Medicel Exemiter must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any jointy or other traumatic event, The Medical Ferrence ADGS.

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

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with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this partitions has been approximated to the Funeral Director. been signed by the attending physician and should be detached for use as the burial-transit ours after death.

neral Director: After this certific filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 DEctopic	pregnancy specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	cause given in Part I.	23e. Did tobaco	o use contribute to the cause of death?
CONGESTIVE	HEART E	FAILURE		1 ☐ Yes	2 No 3 Probably 4 ØUnknown
				24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 1	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred
3 Suicide 6 Could not determined		nome, farm, street, fact ify)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	hysicien: To the best of my kn miner: On the basis of examin and manner stated.				o(s) and manner as stated. and place, and due to the cause(s)

29c. License number

AVENUE

State Registrar 29b. Signature and title of certified

30. Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) NORTH 32. Registrar's Signature

REL AIR

28 2009

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

DIL

			For State Registrar	State of Ma	. y laira /		rtificate of			, ,	No. 2009	31720
	Physici	an	1. Decedent's Name (First, Middle, Las	*		1			M	ite of Death	Day Year	3. Time of Death
4	/Medic	al	George		Waingo:	Ια	41. 07. 7	- Landing of Door		ptembe	r 15, 20	
	Examin	er	4a. Facility Name (If not institution, given Frostburg Vill	,	r Home			r Location of Deat tburg	ın		4c. County of Dea	
5	Funeral Director		5. Social Security Number 6. S		(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	_	8. Da	te of Birth lonth, Day, Ye		thplace (State or Foreign ountry)
			Usual Residence of Decedent								10 1101	
	/arylar f show	ō	10a. State 10b. County MD Alleg		10c. City, Tov		cation aVale					10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	r 28a-	Director	10e. Street and Number				10f. Zip Code	*		10g.	. Citizen of What C	ountry?
	ath with		1260 Vocke	Road			215				USA	
21215-0036	should be filed within 72 hours after death with the Maryland and Mertal Hyglene. I marked other than "natural", or items 23a or 28a-f show martic event, I'm Madical Evanthar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub 1 □Yes 2 🎇 No		Specify Yo to Rican,	etc.)	14. Race - Am Black, Whit	
2-0	72 ho "natur	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	(Give	dent's Usual Occup kind of work done	during most of wo.	rking	168	b. Kind of Business	/Industry
721	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	·)		DO NOT use retire roker	d)			Real Es	tate
פַ	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)				_01101	18. Mother's Nai	me (First	, Middle, Mai		
ylaı	ould by Menta narked	P	Chandler	W	aingol	d		Anna			Silverman	
Ž	d2 th a		19a. Informant's Name/Relationship (Betty L. Waingol			1260	Vocke R	Road, LaV			ity or Town, State, and 215	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1		1	Viev	sition (Name of matory or other pla v Cemeter	y 09/1		09 _ 0	c. Location - City or Cumberlan	d, MD
Ball	permit Depart Import any In		21. Signature of Funeral Service Licer	idens	6						y Funera and, MD	21502
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused tone cause on each line	the death. Do	not ent	er the mode of dyi	ng, such as cardia	c or resp	iratory arrest	,	Approximate Interval Between Opset and Death,
and it	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Enc	1 stay		Dema	ntra				Gmonths
-	Examiner			Due to (or as a	consequence	e or):						
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter uncertainty	Due to (or as a	consequence	e of):						
<u>,</u>	rtificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	consequence	e of):					-	
09/89	ate be hysicia he bur	ledical		.d								
ě	ertific ling pl e as t		IF FEMALE:									
O. Box	w requires that the death cer been signed by the attendir should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	☐ Fetal deat		Ectopic pregnand Other (specify)	cy			23d. Date of de Month	Day Year
<u>s,</u>	requires that the	by Pl	Part II. Other significant conditions of	ontributing to death but	t not resulting	in the u	nderlying cause giv	en in Part I.	2			o the cause of death?
ecords,	r requii been s should	eted										Probably 4 Unknown
r	The larate has	Completed								4a. Was an autopsy performed □Yes 2	prior to death?	utopsy findings available completion of cause of s
VITal	Physiclan: this certific al director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	□ EB/6) d d	oth	26. Place of De				
ם ו	iding Physician; th. : After this certifice ? funeral director, p	n: To	27. Manner of Death	28a. Date of Injury (Month, Day,	t 2 ER/C			ry at	Т —		e 6 Other (Speinjury occurred	ecify)
S S	tendir eath. Ior: Af the fur	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆	lYes 2□No				
DIVISION	al or At after d Direct d in by	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, f (Specify)	farm, str	eet, factory, office		28f. Lc	cation (Stree ity or Town, S	et and Number or F State)	lural Route Number,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C	29a. Certifier 1 Sertifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner stat	examination a	ge, deatl and/or in	n occurred at the ti vestigation, in my	ime, date and plac opinion, death occ	e, and di urred at t	ue to the caus the time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)
1	To th Vithir To th comp	Me	29b. Signature and title of certifier	10 · M	n	***	29c. Licens			29d.	Date signed (Mon	th, Day, Year)
	/0) wowoods	ften "	r		000	055325		S	ep 16, 20	909
	nds		30. Name and address of person who wonsock SHI	1			Print) Walsh	Rd Cu	mbe	rland	40 450.	2
	Sta Registr		31. Date flied (Month, Day, Year) SEP 17 2009	32. Registra	r's Signature		1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 5, 2009 **Physician** 11:56 AM Josephine Waithera /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Burtonsville 3926 Blackburn Lane #43 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Jan 1, 1922 Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □X Kenya Director None 87 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Show in than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Burtonsville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20866 Kenya 3926 Blackburn Lane #43 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc.
African
Specify: American filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No 2 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Njambi ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 so that of Health are: If item 27 is 3926 Blackburn Lane #43 Burtonsville, MD 20866 Dorothy Waiguchu/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 ment of I 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or once. Final Journey Crematory 09/18/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Homes Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Secsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed Dementia and burial-trar Due to (or as a consequence of): O. Box 68760, attending physician for use as the buria Physician/Medical Anemia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Year signed by the a 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe this certificate 1 ☐ Yes 2 ☐ No 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1X Yes 2 □ No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 68782 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Karunwi Adedeji, M.D.

2009

as

Registrar's Signature

7300 Van Dusen Rd Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	For State Registrar	State of Mar	•	Certificate of			leg. No.	009	31722
Ī	Physicia /Medio		1. Decedent's Name (First, Middle, L HAROLD VI	ERNET		WILSO	N	2. Date of Dea Month SEPT	Day	2009	3. Time of Death 0450 AM
-	Examin		4a. Facility Name (If not institution, g	- 1-0	0.01	MILLE	r Location of Death			unty of Death	
ar del	Funeral		5. Social Security Number 6.	Sex 7. Age	OSPITA (In yrs. last birtl	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9 Rirth	MERY place (State or Foreign
H	Director		573-24-9372	1 😿 M 2 🗆 F 📗 - 8	32 Y	rs. Months Days	Hours Min.	Jan. 23	, 192	7 Cal	ifornia
	yland Jow		Usual Residence of Decedent 10a. State 10b. County	1	Ioc. City, Town	or Location					10d. Inside City Limits
	Ba-f sl	Director		ontgomery	Re	ockville					1 □Yes 2 🗷 No
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, Ite Medical Evar ir at must be notified at		10e. Street and Number 14001 London	Lane		10f. Zip Code 20853		1	I0g. Citizer USA	n of What Cou	intry?
	tems ?	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
5-0036	urs afte al", or i Examin	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 [X] Yes 2 □ No If Yes, Give Year or Dates:]		1 □Yes 2 No	Specify:		Sp	ecify: Whi	te
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Maryland 2121	within iene. than '	ldma	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retired Systems	d) -		D esi trat	to Cons	tractor
pu	m = 0 2	Be C	17. Father's Name (First, Middle, Las			by b comb	18. Mother's Nam				cractor
ry la		ြ	Harold T. Wilson		1		Lillian				
a N	d 2 s th ar 17 is 17 is trau		19a. Informant's Name/Relationship Mary Wilson/Wife	(Type. Print)		Mailing Address (Street DO1 London :					ip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1★□ Table Burial 2 ☐ Cremation 3	- Removal from State	20b. Place of cemeter)	Disposition (Name of , crematory or other place	ce) G	Date	20c. Locat	ion - City or T	own, State
Ħ,	it. Pag rtment rtant; I njury o		4 □ Donation 5 □ Other (Spec	ify)	Glasgo	ow Cemetery		09 ¹⁹ ,	Glas	gow, V	irginia
Ba	Depa Impo any la		21. Signature of Funeral Service Lice	Arevala		22. Name and Addre Francis J 500 Unive	ss of Facility • Collins rsity Blv	Funeral	l Home	e Inc.	ng, MD 20901
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	or Attendant after death	ertifi	4 Homicide determined		- At home, fari (Specify)	m, street, factory, office		28f. Location (S City or Tow	treet and N n, State)	lumber or Rui	ral Route Number,
	io the hospital of Atter within 24 hours after de To the Funeral Directo completely filled in by th	ical C	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e	my knowledge, xamination and	death occurred at the ti	me, date and place	, and due to the o	cause(s) ar	nd manner as	stated. to the cause(s)
	o the rithin 24 o the Formplet	Medical	one) 29b. Signature and title of certifier	and manner state	d.	29c. Licens				igned (Month	
	941	65		ewrentur,	nD	D5	9418	6	SEPT	16	2, 2009
	- (30. Name and address of person who	completed cause of dea	th (Item 23a) (1	Type, Print) 1810	PRINCE	PHILIP	DR.	OLNEY	, MD 20832 SPITAL
	Sta	re.	OLUYEMISI 31. Date filed (Month, Day, Year)	O · ADEU	UUNM s Signature	I, MD · N	NUNTGUME	ERY CIE	NER	AL TO	OPITAL
	Registra		SEP 21 20		A. A	all					

Elizabeth Rebecca Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Red. No.

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	Registrar	Certificate of	, Doutin		Reg.	NO.	3. Time of Death
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	4a. Facility Name (if not institution, give street a 243 E. Main Street	nd number)	4b. City, Town, or Elkton	Location of Deatr		Cecil	
Funeral Director	5. Social Security Number 6. Sex 17-94-1584 1 M 2	7. Age (In yrs. last birthday) X F 29 Yrs	If Under 1 Yea Months Day s.			MM/DD/YYYY) 9. Bi Forei 1980 C	rthplace (State or ign ^{ountry)} Mary1an(
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	ation				10d. Inside City Limi
*	Maryland Cecil	E1kton	T		100	Citizen of What Co	1 X Yes 2
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the M. ficat Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number		10f. Zip Code 2192	1	Tog.	United S	
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r death with or items 23 must be no Funeral	Never Married 2 Married 1	Yes 2 X No	Yes, specify Cuba		Rican, etc.)	Specify: Wh	i+0
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21215-0035 Auld be filed within 7 Mental Hygiene. marked other than re event, the M. lica FO Be Comple	12 17. Father's Name (First, Middle, Last)	Wai	tress	18.Mother's Nam	e (First, Middle, Ma	Restaur	Tant
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Baltimore, permit. Pages I ar De partiment of Hes Important: If ite injury or other tr	1 Burial 2 X Cremation 3 Rem 4 Donation 5 Other Specify:	R. A. Ferr	is & Co.,	Inc. 20	09		ester, PA
Saltii ermit.] epartm mporta	21. Signature of Funeral Service Licensee	- 22 <u>.</u> H	Name and Addre	ss of Facility e for Fu	nerals, F treet, El	A. MD	21921
Physician	23a. Part I. Enter the disease, or complications	s that caused the death. Do not enter	r the mode of dyin	g, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Into
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Eth	anol, morphine a	ınd cocai	ne intox	ication		Death
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	30. Name and address of person who complete	eted cause of death (Item 23a) Assistant Medical Examiner	r 111 Denn	Street Raltim	nore, MD 2120	1	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 2009 **Physician** 9:00 PM M ROLAND WESCOTT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 05/25/34 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☑ M 2 □ F 75 VIRĞINIA Director 221-22-6281 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentia Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Director ACCOMACK PARKSLEY VA 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 26463 METOMPKIN RD 23421 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify BLACK þ 3 ☐ Widowed 4 ➡ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 LABORER MACHINES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TILLIE FITCHETT 2 COLBERT WESCOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO BOX 218 PRINCESS ANNE, MD of Disposition (Name of Date ROLAND WESCOTT - SON 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EBENEZER BAPTIST CEM 09/26/09 WARDTOWN, VA 21. Signature of Funeral Service License 22. Name and Address of Facility COOPER & HUMBLES FUNERAL CO., ACCOMAC, VA 23301 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Onknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 22 No 21 Z No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 2[[No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAI Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

SEP 2 1 2009

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day
September 18, **Physician** Year 2009 Chill Fan Yee 5:55 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1⊠M 2□ F 76 Director 212-13-3630 China March 3, 1933 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and it filem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or him transit be rectified at ray or other tranmatic event, Ire Modicel Examinar mast be rectified at 10a. State 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 TXNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2701 Big Bear Terrace Funeral 20906 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wa Yuen Yee ၉ Pu Yon Wong 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fung Shill Chan/Wife 2701 Big Bear Terrace, Silver Spring, MD 20906 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State th Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 2009 24 Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Bladder Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed Exami and burial-trar Due to (or as a consequence of): Box 68760. physician s the burial Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year Day 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ∏ Yes 2 TXNo Other: 4 Nursing Home 5 Residence 6 MOther (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Plymitin 24 hours after death.

Ye the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 163748 September 20, 2009 Koucet thou, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, MD 1355 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 21 parket Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2009 tobe /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Namel (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 F 215-22-1817 Yrs **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 □ No Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: þ Blac 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed went of Health and Mental Hyginnt: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (9 and 50n) Department of Health Important: If item 27 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12009 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph L. Russ Funeral Home, P. A 2222 W. North Ave. Baito. Md. 21: 21. Signature of Funeral Service Licenses anyi Part / Enter the // ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shud, or heart future. List only one cause on each line. Approximate Interval Between Onset and Death Immedi e Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** 4 EARS GASTREVINIESTANA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical y the attending photoe of the ched for use as the Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 📉 Vo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 3 Probably 4 ☐ Unknown 2 🗌 No 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? OF STROKE 24a. Was an Jas autopsy performer? Yes 201No STEWOOD 1 □ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is a relative to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manne stated 29d. Date signed Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person

Year)

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

NO.

o completed cause of death (item 23a)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Edith Kathryn Boram October 2009 11:30 a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Min. Hours Months Days 1 □ M 2√2 F 217-34-9059 22, 1914 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 International Circle Apt. 303 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail - Huszler Store <u>Gift Wrapper</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John C. Seifert Margaret M. Knight 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. JoAnn Landerkin (Dauchter) 2202 Taylor Ave. Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10/5/2009 Parkville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville
8800 Harford Road, Parkville Many and 21234 21. Signature of Funeral Service Licens 23a. Part 1. Intervie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestinal bleed disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hernia 2 No 3 Probably 4 Unknown 1 Tes Previous GI Sleed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an of autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending p the a has this

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ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, It of Nexical Examinations to excliffed at

2 should be filed within 72 hours after and Mental Hygiene.

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permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any injury or other traumatic ev

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sames

Pet:t

OCT 0 5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2 To the I

State Registrar

DHMH 17 Rev 1/2001

5+

N. Charles

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0069485

Ralfimore, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Bonnie Marie Beard 3:43 p 2009 October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Physician /Medical **Examiner Funeral**

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	6514 Ridenour		2B			sville			Carro1	
	5. Social Security Number	6. Sex 1 □ M 2 🖫 F	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, Da	ay, Year)	Co	hplace (State or Foreign untry)
	218-52-0408	1 - W 2 - X	60	Yrs.			Feb. 16	, 194	.9	MD
	Usual Residence of Decedent		10-	03 - T						10d. Inside City Limits
_	10a. State 10b. County		100	. City, Town or Lo	cation					
용	MD Car	roll		Syke	esville					1 □ Yes 2√√ No
jre	10e. Street and Number			-	10f. Zip Code			10g. Citize	en of What Co	untry?
al	6514 Ridenour	Way, Apt	. 2B		2178	4			USA	
ner	11. Marital Status	12. Was Dec	edent Ever	in U.S. 13.	Was Decedent of I		(Specify Yes or No) 14	1. Race - Ame	
교	1 ☐ Never Married 2 ☐ Marrie	Armed Formed 1 Tyes If Yes, G	2 No				rio nican, etc.)		Black, White	e, etc.
þ	3 X Widowed 4 ☐ Divorced	If Yes, G Year or [oates:		1∐Yes 2∭No	Specify:		8	Specify: โม	hite
Be Completed by Funeral Director	15. Decedent's	s Education		16a. Dece	dent's Usual Occu	oation		16b. Kind	d of Business/	
ble	(Specify only highest Elementary/Secondary (0-12)	College (life.	kind of work done DO NOT use retire	auring most of w d)	orking	-		
ē	12	College (1-401 3+)	Com	outer Ana	lyst		Soc:	ial Sec	curity Admin
e	17. Father's Name (First, Middle, L	ast)				18. Mother's Na	ame (First, Middle			
To B	James Franci	c Baker				Retty	Jean Ste	anhan	2	
F	19a. Informant's Name/Relationshi			19h Mailir	ng Address (Street					Zin Code)
			_							
	Sean David Bear 20a. Method of Disposition	d	Son_		Bueno Vi		., Baltin		MD 212 ation - City or	
	1 X Burial 2 ☐ Cremation	3 🗆 Removal from	State		sition (Name of matory or other pla				ation - Oity of	Town, State
	4 ☐ Donation 5 ☐ Other (Sp.	ecify)			ts' Cemet		/5/09	Reis	stersto	own, MD
	21. Signature of Funeral Service L	icensee		22	2. Name and Addre	ess of Facility	11824	Reist	terstow	n Road
	HXD	-		E	line Fune	ral Home	e Reist	ersto	an, MD	21136
	23a. Part 1. Enter the disease, or o shock, or heart failure. List o	complications that	caused the							Approximate Interval Between
	Immediate Cause (Final	A :	+lapr	neclem	tic ca	rdiova	reular	di	(011Ce)	Onest and Death
	disease or condition resulting in death)			nsequence of):	THE CA	.101000	ocotia.	G (ه-ر دار مار	3 years
		Due to	iabo	0 +0 C	nellit	10(
ē	Sequentially list conditions,	b. Due to		nsequence of):	11-6 6617	VI-				10-0
Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•	,	,					Į.	
ха	that initiated events resulting in death) Last	c	(or as a cor	nsequence of):						
alE		L.	,	,						
dic		d								
Me	IF FEMALE:	00- 16								
ian/	23b. Was decedent pregnant in the past 12 months?		birth 2 🗌	Fetal death 3	Ectopic pregnan			23	3d. Date of del Month	lívery Day Year
Sic	1 □ Yes 2 MNo 9 □ Unknown	4 ∐ Preg 9 □ Unk	gnant at time nown	of death 5	Other (specify) _					,
by Physician/Medical Examiner		1			4.4.4.		A0 - F11	toboo		the cause of death?
Ş	Part II. Other significant condition	_	h ho V	- (s two l					
	lung canc	1			3110011		_ 1 🗆	Yes 2□	No 3 P	robably 4 ☐ Unknown
Set	pulmona	n du	sease	2			24a. Was		24b. Were at	utopsy findings available
Ē								ormed2.	death?	completion of cause of
Be Completed	25. Was case referred to medical					OF Place of D	1 L Yes	2 XNo	1 ∐ Yes	2 □ No
	examiner?	Hospital:		2 ER/Outpatier	Otl	or:	eath (Check only			
Ĕ	27. Manner of Death	28a. Date		28b. Time of	IL 3 DOA	4 🗀 Nursing	Home 5 ARes 28d. Describe			сту)
io	1. Natural 5 ☐ Pending	(Moi	nth, Day, Yea	ar) Injury	Wo	k?]Yes 2 □No	Zod. Doscribe	now injury	00001100	
Sa	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	otho	a of laises	At home form of		1165 2 110	20f Location	(011	Alumbar of C	um I Davida Mumban
ŧ	4 ☐ Homicide determin	ned 28e. Flac build	ling, etc. (S	At home, farm, str pecify)	eet, lactory, office			wn, State)	Number of A	ural Route Number,
ပ္	One Complete	División de		. 1	to annual to the	to a state of the	M			t-t- d
Medical Certification: To	(Check only 2 Medical E	Physician: To the xaminer: On the	basis of exa	/ knowledge, deat mination and/or in	n occurred at the to estigation, in my	ıme, date and pla opinion, death oc	ice, and due to the curred at the time	e cause(s) a , date and p	and manner a place, and due	s stated. e to the cause(s)
Jed	one)	and mai	nner stated.		00- 11			00/1 5 /	olem1 /4 4	th Day Vossi
2	29b. Signature and title of certifier	(111	1 1	nan	29c. Licen				signed (Mont	
		(901d)	0100W	n, MD	D.	53968		Octo	ober 2	, 2009
	30. Name and address of person w	ho completed cau	se of death	(Item 23a) (Type,	Print)					,

State

Ellie Goldbloom

31. Date filed (Month, Day,

32. Registrar's Signature

Cross made Drive #400 Owings Mills, MD 21117

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death 1,2009 **Physician** Jeannette Brown Oct. 11:55a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 850 N. Eden St. n/a Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Feb. 26,1934 North Carolina Yrs Director 212 44 2172 75 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examing must be notified at Yes 2□No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 850 N. Eden Street 21205 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 □No 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes. Give Specify: ğ Specify: black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Doctors Office llth Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Brown Viola Buffalo ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Pia Brown (daughter) 850 N. Eden St. Balto, Md. 21205 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If II any Injury or o 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.10,2009 Balto,Md. ponation 5 ☐ Other (Specify) ature of Funeral Service Licensee Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician accident disease or condition resulting in death) cerebrovascular MONTHS /Medical Due to (or as a consequence of) Examiner diabetes Sequentially list conditions, if any, loading to inimionate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsequence of The law requires that the death certificate be executed Exami Division of Vital Records, P.O. Box 68760,physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? rector, page 2 s autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 2 ☐ Accident 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN D53590 October. 2,2009 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BILO. ADWAY 624 Room Gog SYDNEM DY MO BALTIMORE 21205 MD Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 1, 2009 **Physician** 10:42 A.M Cochran Willard J. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day,) Dec. 24, If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Funeral Months Days Hours **1**√2 M 2 □ F 1935 Maryland 73 216-32-6810 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County d other than "natural", or items 23a or 28a-f show event, the "Matical Experies must be notified at 1 ☐ Yes 2 No Director Harford Maryland Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21085 1507 Old Mountain Rd. S. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2★ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mental Injury or other traumatic event, the Mental College (1-4or 5+) Truck Driver Blake Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ertie S. Privett Garvie J. Cochran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1507 Old Mountain Road S. Joppa, Maryland 21085 Joyce Cochran / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HIghview Mem. GArdens 2009 Fallston, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): resulting in death) /Medical Examiner ne many Sequentially list conditions, if any least submitted cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as consequence of): Examiner physician and strans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as t ed by the attending I detached for use as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an hast autopsy 1 ☐Yes 2 No 2 No After this certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient Certification: To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fil Medical (Check only one)

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,-Year) ----

30. Name and address of person who completed cause of death (Head 23a) (Type, Print)

JIHAUG ITNESSY

4.0

104 PLUMTREE Rd. STEIIS

D00320 78

BEL AIR

29d. Date signed (Month, Day, Year)

telen 02, 2009

21014

09-07538 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lester Dean Diggs State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day Y September 27, 2009 **Medical Examiner** an 43 4 43 Active Name (if not institution, give street and number) n, of Location of Death 4c. County of Death 4b. City, Tov 1350 North Carey Street **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Hours Min. Months Davs Director 216-72-4820 1 M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral Was Decedent Ever in U.S Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Armed Forces White, etc. 1 Never Married 2 Yes If Yes, Give Year 1 Yes 2 No specify: Widowed 4 Divorced þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) todnt of Health and Mental Hygiene.
t: If item 27 is marked other thother traumatic event, the Med 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is mr r traumatic e J(sister) Donal 20c. Location - City of Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place 1 V Burial 2 Cremation 3 Removal from State O Cenctery Donation 5 Other Specify sme. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Homes Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a. Contact gunshot wound to head vamine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical **4a, per ME g896 10/15/09 TT** 23,27,28a-f,perME, g896 10/26/09 TT X UNPENDED X AMENDED 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Completed Records. 24a. Was an autopsy performed' ✔ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one of Vital Be Other DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes ို 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: Natural Yes 2 X No in by the Pending 9/27/09 Fd 4:35 pm FdAccident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3XX Suicide Could not be Baltimore, residence determined (Specify) Medical

and manner stated

29b. Signature and title of certifier

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 V No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 V Yes Nursing Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred subject shot self 28f. Location (Street and Number or Rural Route Number, City Baltimore, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) September 28, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32 Registrar's Signature ORIGINAL

1640 hrs

10d. Inside City Limits Yes 2 No

n of Baltimore

P.A. D

Approximate Interval

Between Onset and

Death

9. Birthplace (State or

Foreign

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 02, 2009 8:40 P. Gerda Maria Deterer October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll County Dove House Hospice Westminster If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🖾 F 68 Germany April 218-62-2590 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State show ral", or items 23a or 28a-f shov 1 ☐ Yes 2 No Directo Hampstead Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21074 United States 19406 Grave Run Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", or Specify: If Yes, Give Year or Dates: White Completed by 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Founder/President Wildlife Rescue, Inc. II/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental Hitem 27 is marked oth Be Annie Lang ၉ Adolf Otto Reuss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 78258 222 Verde Ridge San Antonio, Texas Hannelore A. Perkins (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott Oct. 05, __2009 1 ☐ Burial 2 Ă Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland $4 \,\square\, \mathsf{Donation}_{\mathbb{C}} \,\, 5 \,\,\square\, \mathsf{Other} \,\, (\mathit{Specify})$ 21. Signature of Funeral Service Licensee 22 Name and Address of Facility eaceful Alternatives Funeral & Cremation 2325 York Road Timonium, Maryland 210 on Ctr., P.A. Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. disease, or complications failure List only one cause 23a. Part 1. Enter the shoot, or lear Immediate Cause (Final disease or condition resulting in death) LUNG CANCER ELL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami been signed by the attending physician and should be detached for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has 2 No certificate 1 ☐ Yes 2 No this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify DNE MOVE HOS Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours af To the Funeral Di completely filled in certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Sigr who completed cause of death (Item 23a) (Type, Print) Name

State Registrar 31. Date filed (Month, Day,

			1 - For State Registrar			artment of I		Reg.		0 01730
	Physic /Medi	cal	Decedent's Name (First, Middle, L Norman W. Drem A. Facility Name (If not institution, g	ning, Jr.		4h City Town o	or Location of Death	2. Date of Death Month XPHIMON	30 200 4c. County of Dea	3. Time of Death 2:53 A M
J.	Examir	B	Union Memorial 5. Social Security Number 6.	Hospital Sex 7. Age	e (In yrs. last birthday)	Baltin	more City	8. Date of Birth (Month, Day, Ye 3/2/1959	N/A	thplace (State or Foreign
	Director		214-82-0385 Usual Residence of Decedent 10a, State 10b, County	19€] M 2	50 Yrs.		Hours With.	3/2/1959	Bal	ti., Maryland
	death with the Maryland ims 23a or 28a-f show finant be redfilled at	Director	Maryland II/A 10e. Street and Number			Baltin	more	10g.	Citizen of What Co	1 ☑Yes 2 ☐ No
	death with	Funeral D	414 Calvin I	12. Was Decedent B	Ever in U.S. 13.		218 Hispanic Origin? (Specan, Mexican, Puerto F		Inited St of Americ 14. Race - Ame	a erican Indian,
9600	n 72 hours after de "natural", or Item	ğ	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ₹ N If Yes, Give Year or Dates:	lo	1⊡Yes 2√⊡No	Specify:		ороску.	hite
21215-0036		Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5-	(Give	edent's Usual Occup kind of work done DO NOT use retire Self emple	during most of working d)	g 16b	Kind of Business	·
Maryland 2	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 Is marked other than 's or other traumatic event, Ite Ma	To Be Co	17. Father's Name (First, Middle, Las	Drenning, S		CIL Chipi	18. Mother's Name	(First, Middle, Maid Lou Carte	den Surname)	A. da da
, Mary	and 2 should be ealth and Mental n 27 Is marked o		19a. Informant's Name/Relationship Mrs. Suzarine M.		fe 414	1 Calvin	and Number or Rural Avenue Ba			
Baltimore,	Z = E 2		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	eify)	20b. Place of Dispo cemetery, cre Prospect Cemete	l V	1 200	er 5, 9 'T	Location - City or	aryland
Bal	permit. F Departm Importar any Injur		21. Signature of Funeral Service Lio	My		2325 YO	rk Road T	THOATUM,	l &Cremat Maryland	
	Physician /Medical Examiner		23a. Part1. Einer the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each lin a. her do Due to (or as a	e. cellular a consequence of):	C drown		respiratory arrest,	A	Approximate Interval Between Onset and Death
	in the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. hepat Due to (or as a	a consequence of):	ynotrom	<u>-</u> l			Several year
x 687	leath certificate attending physior use as the l	Medical	IF FEMALE:	a. <u>Ceiluli</u>						one rege
.0. Box	the death c by the attend ached for us	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1:4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal déath 3 [⊒ Ectopic pregnand ⊒ Other <i>(specify)</i> _	су		23d. Date of de Month	livery Day Year
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of Vital Records,	sician: The law r certificate has be irector, page 2 sh	Completed		,				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Vit	ysiciar s certif director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ☑ ER/Outpatie	nt 3 DOA Oth	26. Place of Death	(Check only one)	6 □Other (Spo	noite)
o uc	ding Physician: The n	ion: T	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. Injui Wor	ry at 28	Bd. Describe how in		Sity/
Division	al or Attendi safter death. I Director: A d in by the fu	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not determined	be 290 Place of Inju	ry - At home, farm, sti . <i>(Specify)</i>		Yes 2 □No 28	Bf. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
1	Io the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner state	examination and/or in	th occurred at the ti	me, date and place, a ppinion, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
/	With To t	Z	29b. Signature and title of certifier Danna 2	Donatola	y, MD	29c. Licens	243 8946	29d.	Date signed (Mont Septembe	rh, Day, Year) r 30, 2009
			30. Name and address of person who Danna Dara	completed cause of de totajo M			rial Hos	pital,	MD 212	18
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature .	4 0		1		

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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Joann B. Fowler September 20,2009 8:49 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year 4 Hrs. 8. Date of Birth 1960 9. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours November 25, 48 Washington DC 578-84-3953 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits TX Yes 2 □ No Maryland Prince George's Forest Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5922 Ottawa Street 20745 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2★☐ If Yes, Give Year or Dates: 1 Never Married XX Married 2★ No Specify: Black 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Twelve One Administrative Assistant Dept of the IG 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Brooks Mary Lou Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julius Fowler/Husband 5922 Ottawa Street, Forest Heights MD 20745 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) September 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 25,2009 Brentwood, Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home Inch 21. Signature of Funeral Service Licensee 7,4661 Good Hope Rd SE, Washington DC 20020 Deshaun Watts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Right Lung Mass Large disease or condition resulting in death) Due to (or as a consequence of): b. Metastatic High Grade Leiomyosarcoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 K Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2x No 1 ☐ Yes 1 ☐ Yes 2 No

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trat once.

Physician

Examiner

Funeral

Director

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7 is marked other than "natural", or items traumatic event, the Medical Examinating

1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 9m 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

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Examine Physician/Medical þ Completed certificate Be this

funeral spital or Attending Prous after death.
neral Director: After of filled in by the funer. within 24 hours a

To the Funeral C Hospital

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Division

25. Was case referred to medical examiner? Certification: 27. Manner of Death

Medical

V

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 0 5 2009

5 Pending investigation

6 Could not be

determined

2**X**No

29b. Signature and title of certifie

1 ☐ Yes

1 X Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

Hospital:

28a. Date of Injury (Month, Day, Year)

and manner stated.

2 MD

D0063639

28c. Injury at Work?

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check onl one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1500 FOREST Pothuraju Nagabhyru M.D. SLLVER SPRINC, MID SILEN RD. 32. Registrar's Spnature 31. Date filed (Month, Day, Year)

amend #4a&bper Phy &10ce Per FH G89610/05/09 In State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 46 AM **Physician** JERSME SEPTEMBER 28 2009 MORRIS FINE /Medical 4b. City, Town, or Location of Death Pressure 4c. County of Death 4a. Facility Name (If not institution gives treff and number) Examiner BALTIMORE CO MO BALTIMURE Trunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11 – 12 – 1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**X**M 2□ F MD 12 9578 **Director** 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Baltimore PINESVILLE Director BALTIMORE with the 10g. Citizen of What Country? 13 Pomona South #1 10f, Zip Code PARIENA SUUMES USA 21208 Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify Completed by 3 ₩idowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **REALTOR** REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MOLLY BENJAMIN FINE WIGODNER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS FRIEDMAN/ATTORNEY 409 WASHINGTON AVENUE, SUITE 900, TOWSON, MD 21204 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09-30-2009 | BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CURONARY PRIERY **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No NIA 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARCANET D, EBY MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G896 194694 And / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) sept. 30°, 200°9° Physician 12:26aM Kathleen Fairley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 907 Lenton Ave. Baltimore n/a 8. Date of Birth 1939 9. Birthplace (State or Jan. 26, 1930 Maryland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 16-36-9161 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hylgiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exminer must be notified at any injury or other traumatic event, the Medical Exminer must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore n/a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 907 Lenton Avenue 21212 USA Funeral Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Union Memorial Hosp <u>Nursing Assistant</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Gwaltney Geneva ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21212 Robin Fairley (daughter) 907 Lenton Ave. Balto, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cem. Oct. 6,2009 Balto, Md. 4 Deflation 5 □ Oyne (Specify) 21. Si malure of Fyneral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MITASTATIL BREAK COSLLA. Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Et let drashing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RUSAL Failons 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide

The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760 the has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p rthis c

Baltimore, Maryland 21215-0036

Certification: 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

John 12700 31. Date filed (Month, Day, Year) OCT 0 5 2009

29b. Signature and title of certifier

10753 Faces Rg. 70. 32. Registrar's signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

10018320

horsten villa

29d. Date signed (Month, Day, Year)

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	1	For State Registrar	most)	Ce	rtificate of	Death	2. Date of De	Reg. No.		3. Time of Death
Physician /Medical		. Decedent's Name (First, Middle, L	Maryin E	. Gros	S		SEP	Day 22	Year (1009	7:53 8
Examiner	4	a. Facility Name (If not institution, g		AL	4b. City, Town, o	r Location of Death NO 20 If Under 24 Hrs.	<u> </u>		ounty of Death N/	A place (State or Fore
Funeral Director		. Social Security Number 6. 217-56-8082 Juan Residence of Decedent	1 M 2 F 7. Age (iii yis.	Yrs.	Months Days	Hours Min,	(Month, Da	iy, Year) , 1950		ntry) Naryland
Maryland f show	1	0a. State 10b. County	10c. Ci	ity, Town or L		altimore				10d. Inside City Lin 1 ¥ Yes 2 □
with the Mar ta or 28a-f sl		0e. Street and Number	iumore		10f, Zip Code	21244		10g. Citize	en of What Cou	•
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d 2 should be filed within 72 hours aft with and Mental Hygiens 27 is marked other than "natural"; or retaumatic event, the Medical Exami	nanaldiii	15. Decedent's (Specify only highest s	Education grade completed) College (1-4or 5+)	l (Giv	edent's Usual Occul e kind of work done DO NOT use retire	during most of wor	king	16b. Kind	of Business/Ir	•
be filed v tal Hygid d other event, it		17. Father's Name (First, Middle, La	st)	1		18. Mother's Nar	ne (First, Middle	, Maiden S	Gurname)	
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od 2 st lith and 27 is n r traun		19a. Informant's Name/Relationship Karen Gross	(Type, Print)		403 Battersea					<i>p</i> 0000)
Darmit. Pages 1 ar Department of Hea Important: If item : any Injury or other angle.	1	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	Place of Disp cemetery, cri	position (Name of ematory or other pla	ce)	Date 10/01/09	20c. Loc	ation - City or T ansdowne,	
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g physician and as the burial-transit	Ехапше	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	<u> </u>						
the death cer the attendinched for use	iysiciali/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fer 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	B ☐ Ectopic pregnan			2	3d. Date of deli Month	very Day Yea
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ng Phys fter this neral din		25. Was case referred to medical examiner? 1 □ Yes 2 □ No 27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investiga	4	ER/Outpat 28b. Time Injury	of 28c. Inju		ath (Check only Home 5 ☐ Res 28d. Describe	sidence 6		cify)
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he Hospi in 24 hou he Funer pletely fil	edical	29a. Certifler 1 Certifying 2 Medical E	Physician: To the best of my ki xaminer: On the basis of examin and manner stated.	nowledge, de nation and/or	investigation, in my	opinion, death occ	e, and due to the urred at the time	e, date and	place, and due	to the cause(s)
To the view.	M	29b. Signature and title of certifier	Runt	MD	P21	3071		Se	e signed (Monti	200
5		30. Name and address of person w	Zilbermi	Nt,	900 C	aton	Ave,	BAL	timor	20, MD 2
State Registrar	_	31. Date filed (Month, Day, Year)	62. Registrar's Sign	nature	ald					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Charles William Gauss, Sr. 23, 2009 06:02M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Center Towson Joseph Medical 9. Birthplace (State or Foreign Country) Baltimore, MD 8. Date of Birth (Month, Day, Year)
June 12, 1938 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours M 2□ F 219-26-6891 June 71 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Muchal Ergniner must be notified at 1 ☐ Yes 2 ☐ No Maryland Lutherville Director Baltimore 10f. Zip Code 10g. Citizen of What Country? United States 10e. Street and Number 21093 11 Dublin Drive OF America Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TYes 2 No. If Yes, Give Vi€tinain Year or Dates: 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Service Station Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sue L. Smith John Adam Gauss 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lutherville, Maryland 21093 11 Dublin Drive Mrs. Beverly A. Gauss/ wife Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition jo = 10 September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 25, 2009 permit. Page Department of Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CARDIOMYOPATHY resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed CORONARY ARTERY DISEASE Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Day Month in the past 12 months? 5 Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed res 2 2 No certificate 1 □ Yes 1 □Yes this certific 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be ? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient ဥ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After Medical Certification: To the Hospital or Attending Injury 1 Natural 2 Accident 5 | Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Division of Vital

State Registrar 29b. Signature and title of certifie

KOSHROW

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TABASSI

. D.

32. Registrar's Signature

7601

29c. License number

OSLER DRIVE

D46356

TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2, 2009 Year 11:00A M Arleigh P. Hess, Jr. October 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Fairhaven Ret. Comm. Sykesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1⊠ M 2□ F 91 02/16/1918 169-16-4190 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Sykesville Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 U.S.A. 7200 Third Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify If Yes, Give Year or Dates: WWII Specify White ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie McClelland Arleigh P. Hess, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Hess/Daughter 11145 Windsor Road Ijamsville, MD. 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Doylation 5 Dother (Specify) S. Carroll Crematory 10/04/2009 Winfield, MD. 21. Signature of Funeral Service L 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road & Crematory, P.A. Winfield, MD. 21784 23a. P. rt.1. B ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm diate Cruse (Final dise se or or ndition resulting in eath) ocurdo Due to (r as a consequence of) Dertensio Due to (pr as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year

Physician /Medical Examiner

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Department of IImportant: If ite
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10a. State

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

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s been signed by the attending physician and should be detached for use as the burial-tran certificate has page 2 s director, Certification: To funeral After death.

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu State Registrar Sequentially list conditions, if any leading to in modulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE

9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 12 Natural

2 Accident

4 Homicide

29b. Signature and

3 ☐ Suicide

29a. Certifier

Medical

28a. Date of Injury (Month, Day, Year)

and manner stated

Hospital

5 Pending investigation

6 ☐ Could not be

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3 Ectopic pregnancy 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 ☐ Yes

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description:

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Idersburg 64

31. Date filed (Month, Day,

Figistrer's Signature Year)

09-07553	
Quinn Hiddleston	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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or 28:	Director	21 Chrysler Place, #6 21228		IISA	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions and the purial or transitions.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and do one) Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time.	ue to the cause(s the time, date an	o, and manner as sta d place, and due to	the cause(s)
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		Man Brassell MD O.C.M.E.	;	September 28,	2009
		30. Name and address of person who completed cause of death (Item 23a)			
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
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			a. Facility Name (if not institution, give street and number) Garrett County Hospital			Location of Dea	ath	4c. County of De Garrett	ath		
Eumanal	-		Sex 7. Age (In yrs. lasi	t birthday)	Oakland If Under 1 Year	If Under 24h	irs. 8. Date of Bir	th (MM/DD/YYYY) 9.	Birthplace (State or Foreign		
Funeral Director			X M 2 F	Yrs.	Months Days			19, 2009	Country) Harylews		
<u>*</u>		Usual Residence of Decedent 10a. State 10b. County	10c City To	own or Location	nn.				10d. Inside City Limits		
ow any									1 Yes 2 No		
Maryland 28a-f show 1 at once.	황	10e. Street and Number	Arundel A	- NILD	10f. Zip Code		1	log. Citizen of What C	ountry?		
215-0036 be filed within 72 hours after death with the Maryland antal Hygiene. rked other than "natural", or items 23a or 28a-f shoent, the Medical Examiner must be notified at once	Dire	1271 SemINO	le Prive		7/	UZ		U.5A.			
th with	as I	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?		Decedent of His		Specify Yes or No rto Rican, etc.)	14. Race - An White, etc	nerican Indian, Black,		
fter deat	y Fun		1 Yes 2 No	1	Yes 2 No	specify:		Specify: \	white		
ours a atura	d b	15. Decedent's Education (Specify	only highest grade completed) 1		's Usual Occupat			16b. Kind of Busine	ss/Industry		
6 172 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	duning mo	_		cured)	INFAS	vT		
5-0036 led within 72 Hygiene. other than the Medical	E	0 17. Father's Name (First, Middle, Las		_	INFA		me (First, Middle,				
D 21215-0C should be filed win and Mental Hygien 7 is marked other	Bec	Luigi	R_{or}	مبهه			+M1C	1+1e	Menz		
2 B M E 2		19a. Informant's Name/Relationship		19b. Mailing	Address (Stree	et and Number	or Rural Route Nu	mber, City or Town, S	tate, Zip Code)		
		Luisi Roman	- Father	516	Wood	Duck	LANC A.	Nampolis,	MA Z 1409 yor Town, State		
ore, Mes I and 2 of Health		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. Pla	ace of Disposi ematory or oth	tion (Name of cer er place) んとい	metery,	Date	20c. Location - City	or Town, State		
		4 Donation 5 Other Speci	ς _τ .	Joseph	Catho	lic "	7-29-09	BAUSM	AN, PA		
Baltimore, permit. Pages I an Department of Her Important: If ite		21. Signature of Funeral Service Lice	ensee	22. N	ame and Address	of Facility	JOSEPH N	. ZANNIA	AN, PA		
	\dashv	23a Part I Provide diseas or con		s St-	BAIL	Approximate Interval					
Physician /Medical		failure. List only one Juse on each line. Between Onset a Death									
xaminer	1	Immediate Cause (Final disease or condition resulting in death)	Asphyxia Due to (or as a consequence of):								
		Sequentially list conditions,	0								
	je.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):								
118:_ =	Examiner	(Dieases or injury that initiated events resulting in death) Last	Due to (or as a consequence of):								
760, cate be executed physician and the burial - transi			d								
760, icate be expensed by physician the burial	/Medical	UNPENDED	AMENDED					004 8-4-464-1			
		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregna		al death 3	Ectopic pre	gnancy	23d. Date of deli Month	Day Year		
ox 6	icia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of deat	_ = =	ner (Specify)			l.			
Records, P.O. Box 687 The law requires that the death certific cate has been signed by the attending; page 2 should be detached for use as th	Physician	Part II. Other significant condition	9 Olikilowii	ulting in the u	nderlying cause /	niven in Part I	23e Didi	tobacco use contribut	e to the cause of death?		
rds, P.O. requires that the been signed by the thould be detached.	ē	Fast ii. Other significant condition	continuum to death but not res	sularing in the o	nderrying cause (giveri ili i aiti.			Probably 4 Unknown		
ords, w require	Completed			_	<u> </u>		24a. Was		e autopsy findings available		
COT law rathas b	롈							ormed? deat			
tal Reco		OF 18/22 and referred to modifical			26 Plane	e of Death (Che	1 (4-1	2 No 1 🗸	Yes 2 No		
Vital ysiclan: his certif	B	25. Was case referred to medical examiner?	Hospital: 1	R/Outpatient	-	Othor	rsing Home 5	Residence 6 C	Other:		
n of Vital Records, ing Physician: The law requir . After this certificate has been si funeral director, page 2 should b	5	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Ir		ry at Work?	28d. Describe	how injury occurred			
ion of Vital P tending Physician: eath. ior: After this certifi the funeral director,	흲	1 Natural 5 Pending	Con 10, 2000	FOUND: 1930 hrs	1	Yes 2 🗸 No	Subject as	pnyxiated			
Division all or Attending a for Attending a for death.	ifica	2 Accident Investig. 3 Suicide 6 Could no	28e Place of Injury - At hon		t, factory, office t	building, etc.	28f. Location or Town,		r Rural Route Number, City		
Div Hospital or 24 hours afte Funeral Dis	Certification:	4 V Homicide determin	1-p				752 A Overlo	ook Pass, McHenry			
the hin the	Medical	29a. Certifier 1 Certifying Physone) Medical Examir	ician: To the best of my knowledge er:On the basis of examination and	e, death occur d/or investigat	red at the time, di ion, in my opinior	ate and place, n, death occurre	and due to the cau ed at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)		
To Witi	Me	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)		
		Glank his			O.C.	M.E.		September 2	1, 2009		
_ \		30. Name and address of person wh Mary G. Ripple MD. D	o completed cause of death (Item 2 eputy Chief Medical Exam		Penn Street	t. Baltimore	. MD 21201	1			
\ 	ate	31. Date filed (Month, Day, Year)				.,	, 2.201				
Regist		OCT 0 5 2009	32. Registrar's Signature	Barker							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9/30/2009 12:35P M Sharon M. Hoshall /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/24/1938 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 1 □ M 2 💢 F Yrs. 71 Iowa 212-36-4690 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Institute Examined must be reconsidered. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21228 1001 Spring Gate Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify White Specify: <u>Á</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Packer Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Elliott Viola Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOnald B. Hoshall / Husband 1001 Spring Gate Road, Catonsville, Maryland 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 10/3/2009 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 MOS **Physician** ANCREATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 5 Other (specify) been signed by the Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs The certificate 2 No 1 ☐ Yes 2 No 1 □ Yes Vital Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1□Yes 2No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At Jome, farm, street, factory, office building, etc. (Sp ify) filled in by 4 ☐ Homicide ō 1) Certifying Physician: To the best of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the company. 29a. Certifier Medical xamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner sta 29d. Date signed (Nonth, Day, Year) 29c. License number 29b. Signature ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32/ Registrar's Signature Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2009 **Physician** Bonnie L. Hohenberger 10:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/19/1947 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 F 217-46-4911 62 Yrs Baltimore, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 United States 1311 Whitman Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White à 3 Midowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping/Receiving Operations Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Tillman Richard Dorsey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jessica L. Sullivan (Daughter) 105 Forest Street, Glen Burnie, Maryland 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/07/2009 Meadowridge Memorial Elkridge, MD 4 Domation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licens 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complication; 11 it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one construction. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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28a-f show

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than

permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or other trau

State Registrar 29b. Signature and title of certifie

30. Name and address of pers

31. Date filed (Month Day,

29d. Date signed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedent's Name (First, Middle, Lest) CMonth **Physician** LARINA JOYNER 2009 /Medical 4c. County of Dea 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Itimore Manor 5. Social Socurity Number hab. 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 20 F 9 Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1832 Race - American Indian, Black, White, etc. deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Naver Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 📜 No Specify: Specify: Blac Completed by 3 Widowad 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry end Mantal Hygiena. In marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pegas 1 end 2 should be Ober ownes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Son) 20b. Place of Disposition (Name of cometery, crematory or other place) Balto.Md 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph L. Russ Funeral Home, P.A Balto. Md. 21216 2222 W. North Ave. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Se esn for use es 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Upknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? has 2 3 M 1 □ Yes 2 □ No 1 🗆 Yes funerel director. Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Certification: To 1 ☐ Yes 2 110 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Narsing Home 5 ☐ Residence 6 ☐ Other (Specify) this arter death. N Director: After the in by the ferm 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital o within 24 hours at To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Pript) 1009 31. Date filed (Month, Day, Year) OCT 0 5 2009 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Year 9 1. Decedent's Name (First, Middle, Last) Month IC PM **Physician** 3 200 EATRICE TAMES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE RAN DALLSTOUN RANDALLSTONN TENESIS If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Months Days 1 □ M 2 X F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 23a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Dikesville MD Baltimore **Funeral Directo** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number iourt 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private area ver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) salle Wade 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name (Belationship (Type. Print) Pikasuille, MD 21208 Court 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ling Men Will Park 20a. Method of Disposition Date Windsor Mill, MD 1 ■Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral Soulles 8728 Liberty Roud Randaustow) MD 21133 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RTERY ORONARY **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed^a 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Inversing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year)

30 Hame and address of person who completed cause of death (Item 23a) (Type, Print)

9109 LIBERTY ROAD WHITEFORD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Char	les Thomas		I- For State	tate of Mary	yland / [tment of ificate of			Menta	al Hyg		Reg. No.		
	Physicia	an/	Registrar 1. Decedent's Name (First, Mide									. Date of Dea Month	ath Day Year	.]	3. Time of Death
Med	lical Exami	ner	Charles Thomas									Septemb	er 18, 2009 4c. County o		2008 hrs
			4a. Facility Name (if not instituti Franklin Square Hos	-	number)		4	Rosed		ocation of	Death		Baltimore		
	Funeral		5. Social Security Number	6. Sex	7. Age (n vrs. las	t birthday)	If Unde		If Under	24Hrs.	8. Date of B	irth(MM/DD/YYYY)	9. Birt	hplace (State or
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	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral		1 Ye	d Forces?	No					1 0611011	tioan, ctc.,			
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		ပ	19a. Informant's Name/Relation	nship (Type, Print)			19b. Mailing	Address	(Street	and Num	ber or Ru	ural Route Nu	ımber, City or Tow	n, State	, Zip Code)
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. 1	376 ficate g phy s the t	n/M	IF FEMALE: 23b. Was decedent pregnant in	AL a	es, outcome ive birth	of pregn		tal death	3	Ectopic	pregnar	ncy	23d. Date of Month		'y Day Year
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11	of V ng Phy After th	Ë	1 ✓ Yes 2 No 27. Manner of Death	28a.	Date of Injury	<u></u>	28b. Time of	Injury	28c. Injur Unkn	ry at Work			e how injury occur		-
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	Division tal or Attendi rs after death. al Director:	lig.	2 Accident In	vestigation 28e.	Place of Inju	ıry - At ho	me, farm, stre	et, factory	, office b	uilding, et	tc.	28f. Location or Town		er or R	tural Route Number, City
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		-	hell.		_	MI)		O.C.	M.E.			Septembe	r 19, :	2009
			30. Name and address of pers	on who completed	cause of de	ath (Item	23a)								
	- 1		Russell Alexander N		nt Medica			Penn	Street,	Baltimo	ore, MI	D 21201			
	S Regis	tate	400 AT ATO AT 1 140	She	2. Registrar'	s Signatu	park	1	-						

ORIGINAL.

		-	For State Registrar	State of Maryla		rtificate of D			eg. No. 2 0	09 3174		
			Decedent's Name (First, Middle, La	st)				2. Date of Deat	h	3. Time of Death	_	
P	hysicia/ Medic/		Evelyn	Altha Morgan	Kinsl	.er		October	~ -	Year 009 12: 40 4 M		
) •	Examin		4a. Facility Name (If not institution, giv		4c. County of	of Death						
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and	w T	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits	-	
I et, Ivial yialid ZIZIS-0030 I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	ţō	MD Carrol	1	Sykes	sville				1 □Yes 2X No			
	jrec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Country?	-		
	a	2203 Carroll Hig	hlands Ct.		21784				USA			
	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 □Yes 2X No	spanic Origin? (Spen, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. : White			
tural		ted	15. Decedent's Ed	ducation		dent's Usual Occupa		I.	16b. Kind of Bus	siness/Industry		
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O. DOX he death cer	After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>	/		23d. Date Mor	e of delivery nth Day Ye ar		
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lor At after d	급급	() I								cause(s) and manner as stated. date and place, and due to the cause(s)		
LIVI te Hospital or At τ 24 hours after d	ne Funeral Di		29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	miner: On the basis of exami and manner stated.	ination and/or ii	nvestigation, in my of				and due to the cause(s)	_	
To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death.	To the Funeral Discompletely filled in	Medical ((Check only 2 Medical Exa	miner: On the basis of exami	ination and/or ii	29c. License		2	29d. Date signed	d (Month, Day, Year)	_	
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DHMH 17 Rev 1/2001

Kinsler, Evelyn

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7&8 Per FH C896 10/06/09 III
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Judith Ann Lafferty 3:00 P M 9/29/2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 3547 Benzinger Road Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 □ M 2 🕅 F 73 6/10/1936 280-30-2469 Director Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner naust be notified at Director 1X Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3547 Benzinger Road 21229 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 □Yes 2 🛛 No Specify White Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 0 College (1-4or 5+) Candy Maker Retail Mfg. Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Lawrence E. Christman Mary E. Shelton and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau John W. Lafferty / Husband 3547 Benzinger Road, Baltimore, Maryland 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemtery | 10/2/2009 | Baltimore, Maryland 21. Sunature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform 2 🗆 No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number D 1 6 3 5 4 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 19, ^{Year} 2009 **Physician** 5:45 P M Maxeyne Lyons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Collingswood Nursing & Rehab Center Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 1919 Texas 458-20-7667 90 14, Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f shov "natural", or items 23a or 28a-f show 1 XYes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 5012 Russett Road 20853 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) ages 1 and 2 should be filled wi ent of Health and Mental Hygier It: If item 27 Is marked other th y or other traumatic event, this Postal Worker United States Postal Svc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Thomas Edison Stringer <u>Carrie Lea Henson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5012 Russett Rd., Rockville, MD 20853 Sharron Houlihan (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 9/24/09 5 ☐ Other (Specify) 4 Donation Pleasant Hill Cemetery Bryans Mill, TX 22. Name and Address of Facility Harrison Funeral Home 21. Signature of Funeral Service L Seller 500 WL Dodson Blvd., Naples, TX 75568 lemis () Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a. Failure to Thrive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Aspiration Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Dementia burial-trai Due to (or as a consequence of) 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 X No 1 □Yes 2 □ No 1 ☐ Yes or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check onl one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2

0 State 29b. Signature and title of certifier

Marcia Goldmark, 31. Date filed (Month, Day, Year)

OCT 05 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sinature

8

Registrar DHMH 17 Rev 1/2001 Dark

29c. License number

D0025348

15020 Shady Grove Rd. #300 Rockville, MD 20850

29d. Date signed (Month, Day, Year)

September 21, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month) **Physician** Year Lowe 2001 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brehm 21151 Vestminster, MD If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 9. Birthplace Gountry) Age (In yrs. last birthday **Funeral** Days 228468126 1 1 1 M 2 □ F Hours Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show event, the Medical Exandrer must be notified at Director 1 ☐ Yes 2 🔽 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1243 Brehm Road 21157 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any Injury or other traumatic event Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No \$ 1961-63 Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jay Albert Lowe Myrtle Inscore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Francis Estelle Lowe (Wife) 1243 Brehm Road, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 10/3/09 Finksburg, MD 21. Signature of Funeral Service Ligens HAIGHT FUNERAL HOME & CHAPEL PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or conpil ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mylcardial /Medicai resulting in death) (or as a consequence of) Examiner Stage and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Hyperlid Coma Due to (or as a consequence of): physician a s the burial-t Box 68760, Smoken Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 morths? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Ö Yes 2 M 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 🗌 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 s autopsy certificate 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Tes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

Records, Division of Vital within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the

State

Registrar DHMH 17 Rev 1/2001 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1726-44. 6. Schlemff, MD 16918 You

29c. License number

York Road Suite 100 Monkton, mi)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Per FH G896 10/05/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** October Joyce B. Lurz 3,2009 2:15 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville 3038 3rd Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Months Days Hours Min. August 22, 1927 | Mary Land 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 □ XF 212-24-8706 Director 82 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Baltimore 1 ☐ Yes 2 ▼No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 3038 3rd Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates Specify: white ģ 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Comptometer Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruby Roth Edward Bastress ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry J. Lurz-spouse 3038 3rd Avenue-Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVANS FUNERAL CHAPLL AND REMATTON SERVICES BELAIR 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Oct. 5,2009 21. Signature of Funeral Service Licensee 22. Name and Address of Faci EVANS FINERAL CHAPPL AND CREMATION SERVICES 8800 Harford Road-Parkville, Maryland 21234 trololi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) the 9 Unknown 9 Unknown þ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been significate base 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1∐ Yes 2⊿No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours anter ...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 146 97 30. Name and address of person mpleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

OCT 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene® Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 01, 2009 2:10 A. M Catherine Barbara Leutner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore County Timonium Stella Maris 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 28,1911 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Baltimore, MD. 1 ☐ M 2 🕮 F 98 216-05-0544 Yrs. Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Timonium Baltimore County Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 2300 Dulaney Valley Road 21.093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married 1∐Yes 2∐iNo Specify: White 3 Nidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College, (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louisa Pesagno Charles Lamm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21093 Timonium, Maryland 12 Spyglass Court Charles Albert Leutner, Jr. (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Oct.03,2009 1₺ Burial 2 Cremation 3 Removal from State Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part Enter the disease shock, or heart failure e, or complications that caused the death. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, a. END Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Examiner death certificate be executed and-trar physician ar the burial-tr P.O. Box 68760 attending p ed by the a signed by t i be detach The law requires that Division of Vital Records, CATHERINE s peen s has certificate Hospital or Attending Physician: After this funeral dir

Physician

/Medical

Examiner

Directo

Funeral

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Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Modical Exeminer must be rediffed at

Physician

/Medical

Baltimore, Maryland 21215-0036

OCTOBER

Examine by Physician/Medical Completed Be Certification: To within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

cal Medi

State

Registrar

		1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hol	me 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place, miner: On the basis of examination and/or investigation, in my opinion, death occurr	

X NURSE PRACTIFICATER 29b. Signature and Itle of gertifier

29d. Date signed (Month, Day, Year) 29c. License number

TIMONIUM

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MD

21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY ROAD

31. Date filed (Month, Day, Year) OCT 05 32. Fegistrar's Signature

To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2005 Oct. 3 12:40P. M Helen Kennedy Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Maiden Choice Lane Baltimore Catonsville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖸 F 216-07-0224 Director 6, 1917 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 ☑ No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Maiden Choice Lane 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√ No þ Specify. White 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Glenn L. Martin Co. instrument Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret May Henderson James Kennedv ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3849 Elmcroft Road Randallstown, MD 21133 HelenClare Dorman daughter permit. Pages 1 and Department of Heali Important: If Item 2 any Injury or other once. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery Oct. 6, 2009 Pikesville, MD 4 Donation 5 Other (Specify) Entombment 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final **Physician** pars disease condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending ours after death.

neral Director: Al
filled in by the fu 2 Accident investigation 1 □Yes 2 | No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 30984 October 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar appointer

31. Date led (Month, Day,

DHMH 17 Rev 1/2001

Maiden Choice Lane Cotonoville MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:30 A 9 **Physician** Inna /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner han 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, (In yrs. last birthday) Funeral Min 65 212-4404 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Department of Health and Mental Hygiene. Important: if item 271 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exactination in the modified at once. 1 Hres 2 No timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2121 14. Race - American Indian, . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: be filed within 72 hours after 1 Never-Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify ģ DIAC 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rocessor 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last). Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a) Informant's Name/Relationship (Type. Print) On Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20h 20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 Removal from State 000 4 □ Donation 5 □ Other (Specify) ature of Funeral Service License (to. m) 21281 23a. Part 1. Ends the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician > /Medical Due to (or as a consequence of): Examiner Due to (or as Insequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 mont 5 Other (specify) 1 ☐Yes 2 ☑No 9 Unknown certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐Yes 2 1110 director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1∐Yes 2 ₽No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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State Registrar Month, Day, Year)

32. Registrar's Signal

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(Item 23a) (Type, Print)

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State of M	aryland / Dep <i>Ce</i>	artment of F ertificate of			iene.	31755
Physicia		1. Decedent's Name (First, Middle, Last) Dorothy Mae	Moyer			2. Date of Death Month Octobe	Day Year	3. Time of Death 5:00 a M
/Medica Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death	OCCODE	4c. County of Death	
Funeral		Genesis Helath Care 5. Social Security Number 218-22-4664 1 M 2 ZF 7. A	ge (In yrs. last birthday,	1	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9/6/192	9. Birth	place (State or Foreign ntry)
Director		Usual Residence of Decedent				9/0/192		10d. Inside City Limits
Maryla	tor	10a. State 10b. County Charles	10c. City, Town or L	Plata				1 ∑X yes 2 □ No
with the 3a or 28s at be noti	Funeral Director	10e. Street and Number 1 Magnolia Drive	1	10f. Zip Code	646	10	Og. Citizen of What Cou	ntry? JSA
Irs a	þ	11. Marital Status 1 Never Married 2 Married 3 Xwidowed 4 Divorced 12. Was Deceden Armed Forces 1 Yes 2 X If Yes, Give Year or Dates	[No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: Whi	etc.
within 72 hou ene. than "natura	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	edent's Usual Occup e kind of work done DO NOT use retire H omemaker	oation during most of work d)	ing	16b. Kind of Business/Ir Own Home	idustry
d be filed vental Hygic ked other c event, th	To Be Co	17. Father's Name (First, Middle, Last) William Bert Creamer Sr			18. Mother's Name		Maiden Surname)	
INIAI y nd 2 shoul slith and M 27 is marl r traumati	ř	19a. Informant's Name/Relationship (Type. Print) Patricia L. Simon / Daugh	I	ing Address (Street Redbay R			; City or Town, State, Zi	p Code)
Pages 1 ar nent of Hee nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, cre Ardent C	ematory or other pla	ce) !	3/2009	20c. Location - City or T Hanover,	
permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Liceasee Dorota	3.4	22. Name and Addre Marylan			rvices e, MD 212	203
Physician /Medical Examiner	her	resulting in death) Due to (or a U1 Sequentially list conditions	ad the death. Do not entine. Posis s a consequence of): inary Tra s a consequence of):			or respiratory arre	est,	Approximate Interval Between Onset and Death
of of or cate be cate be physicial the bur	dical Examiner	that initiated events c.	s a consequence of):					
death certified attending ed for use as	Physician/Me		2 ☐ Fetal death 3 at time of death 5	☐ Ectopic pregnand	су		23d. Date of deli Month	very Day Year
aw requires that as been signed be dete	ا ک	Part II. Other significant conditions contributing to death Weight Loss, Fever	but not resulting in the	underlying cause giv	en in Part I.		oacco use contribute to es 2 <mark>X</mark> No 3□ Pro	
al neco	Completed					24a. Was ar autops perforn 1 □ Yes 2	ry prior to c med? death? 2 ½ No 1 □ Yes	topsy findings available ompletion of cause of
ysician; Tysician; Tysician; Discertifica	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpa	tient 2 ER/Outpation	ent 3 DOA Oth	26. Place of Deat ner: 4☑ Nursing Ho		e) ence 6 ☐ Other (Spec	sify)
ding Phy h. After this funeral of		27. Manner of Death 1 XNatural 5 Pending (Month, D	jury 28b. Time Day, Year) Injury	Wor	ry at rk?]Yes 2 □No	28d. Describe ho	ow injury occurred	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	ertification:	3 Suicide 6 Could not be determined 28e. Place of \$1	njury - At home, farm, s etc. <i>(Specify)</i>			28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
Hospite 24 hours Funera stely fille	Medical C	29a. Certifier (Check only one) 1 X Certifying Physician: To the besis and manner:	of examination and/or					
To the within To the comple	Me	29b. Signature and title of certifier		29c. Licen:	se number 54547	2	9d. Date signed (Month	, Day, Year)
4		30. Name and address of become who completed cause of W. Crittenden, M.D.			l, Suite 3	50 . Roc	ville. MD	
Stat Registra			trar's Synature		•	,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2000 osier mm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number Itimore Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 214-26-5542 Aua Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. In Pages 1, the marked the Important; if item 27 is marked other than "natural" or items 23a or 28a-f show any in Jury or other traumatic event, I'm Marical Examinar must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number)(0 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No 3 Nidowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Maryland Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Helationship (Type. Print) 806 Stablersuille Markton mb 21120 on 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🖫 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, mD rarkwood Cemetery Oct 3,2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Picility
Evans Funeral Chapel + Cremation Services 21. Signature of Funeral Service Licensee 8800 Harford Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to him solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Month Day 5 ☐ Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes certificate has 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Sursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 1 Inpatient 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

Division of Vital Records, WOSIER,

Box 68760.

Ö

Baltimore, Maryland

Hospital or Attending within 24 hours after death. To the Funeral Director: A

> State Registrar

EDDIE NAKHUDA, M.D. 31. Date filed (Month, Day, Year) OCT 05 2000

29b. Signature and title of

2300 DULANEY VALLEY ROAD 32. Resstrar's Signature

Z

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dark

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM

10-2-2009

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** a Mes /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Country) **Funeral** 7-52-2998 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ms 23a or 28a-f sho must be notified at 1 Yes 2 ☐ No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten 1 Yes 2
If Yes, Give
Year or Dates: 1 X Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education Medical e kind of work done a

DO NOT use retired) (Specify only highest grade completed) Elementa Secondary (0-12) College (1-4 or 5+) DIKE the uth and Mental Hygier 27 is marked other the traumatic event, the 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) (Friend) P other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Method of Disposition j_o 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State ortant: if i Department o Important: if any injury or once. GreenMount 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses oh L. Rus W. North Approximate Interval Between Onset and Death Pay 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No Ves 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

LUROWSK 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 0 5 2009

VASON

29b. Signature and title of certifier

Barker

RES-000

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 45 per FH G896 10/13/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 MARY **PUSKAR** OCTOBER 1:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F Months Days Hours 91 Director Oct. 31, 1917 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, The Medical Examinat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director MD Baltimore 1 ☐ Yes 2 No Parkville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3340 Woodside Avenue 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: White ₫ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Gyourko Joseph Timko ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gerald Puskar/ Son 3028 Linwood Avenue, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State Date 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/05/09 Rosechle, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licensee All 1. Enter le disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) **Physician** 1 5 700 /Medical Due to (or as a consequent e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listase or njury that initiated events resulting in death) Last Due to (or as a consequence of): nei or Attending Physician: The law requires that the death certificate be executed Exami the burial-transi Due to (or as a consequence of): Box 68760 by Physician/Medical cate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No Division of Vital 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral s after death, i Director: After t 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural | 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerai Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aturer 2, 2007 D32299 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State UCT 05 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 200^{yea} October 3:25am м Harold Quenzer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2994 Brookwood Court Howard Ellicott City If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NV Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Hours ^{Year}1928 1**X**□ M 2 □ F July II NY 219-22-9520 81 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2X☐ No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 2994 Brookwood Court 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) uld be filed within 7 1 Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Westinghouse Corp. Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold M. Quenzer Mary A. Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mrs. Marilyn E. Quenzer (W</u>ife) 2994 Brookwood Court Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 10/6/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 M00764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NON hode disease or condition resulting in death) Medical Due to (or as a consormence of) **Examiner** Sequentially list conditions, Due to (or as a conse juence of) if any, had ing to immedia cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes _2 🗀 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

OCT 05 2009

pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

20b. Place of Disposition (Name of cemetery,

Date

October 3, 2009

29d. Date signed (Month, Day, Year)

Physician Medical aminer

Ariea

e Hospital or Attending Physician: The law requires that the death certificate be execut 124 hours after death e attending physician a Division of Vital Records, P.O. Box 68760, s been signed by the should be detached f s certificate has b To the Funeral Director: After this certificompletely filled in by the funeral director,

- 1	20a. Metrod of Disposition	20b. P	lace of Disposition (Nar	ne of cemetery,	Date	20C. Lucation -	
		(emoval from State	rematory or other place	(1 2	10-10-09	Deind	alkind.
- 1	4 Donation 5 Other Specify	n	t. Carne	l Cem	70 70 01	0-0-0	fass
	21. Signa of Funeral Service Licensee		22. Name and	Address of Facility	270 fred	HILTON	ias
- 8	1 Hard 1 98 beard		lare &	2 march	Fit. Bas	to me	1. 21229
	23a. Van Enter the disease, or complicating the List only one cause on each list.	ne.		of dying, such as o	ardiac or respiratory arr	est, shock, or nea	Between Onset and Death
		to (or as a consequence of					
iner	eause. Enter Underlying Cause	to (or as a consequence of	·):				
Examiner		to (or as a consequence of	():				
dical	UNPENDED	MENDED				23d. Date of	delivery
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fetal death		ic pregnancy	Month	Day Year
			esulting in the underlying	ng cause given in F		tobacco use contr es 2 ✓ No 3	ribute to the cause of death? Probably 4 Unknown
Completed by						opsy formed?	Were autopsy findings available prior to completion of cause of death? Yes 2 No
ပိ	and the medical			26.Place of Deat	h (Check only one)		
o Be	examiner?	pital: 1 Inpatient 2	ER/Outpatient 3	DOA Other	Nursing Home 5	Residence 6	Other:
⊢	27 Monner of Death	28a. Date of Injury Oct 3, 2009	28b. Time of Injury 0228 hrs	28c. Injury at Wo	✓ No Subject sh		
Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	(Specify) Local Stre	et		400 blk Mas	, State) ssachuesetts Av	ber or Rural Route Number, Ci venue, Baltimore, MD
lical C	29a. Certifier 1 Certifying Physician (Check only one) 2 ✓ Medical Examiner:O	: To the best of my knowler on the basis of examination	dge, death occurred at and/or investigation, in	he time, date and my opinion, death	place, and due to the ca occurred at the time, da	ause(s) and mann- ite and place, and	er as stated. due to the cause(s)

3

State Registra

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State C		Certif	icate of l	Death		Reg. No.		
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
Physic /Medi		Robert Edward St					Oct.		2009	12:55 A.
Exami		4a. Facility Name (If not institution, give street and no		41		Location of Death			ounty of Death	
L	Š	13545 A Old Annapolis			Mt. A	Lry If Under 24 Hrs.	O Date of Bird		Freder	
Funeral Director		5. Social Security Number 145−36−9455 6. Sex 1 1 1 1 M 2 □ F	7. Age (In yrs. Ia	. M	onths Days	Hours Min.	8. Date of Bird (Month, Da Jan. 2	v. Year)	45 New	place (State or Foreig intry) Jersey
and ≱ _		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	ion					10d. Inside City Limit
within 72 hours affer death with the Maryland ene. than "naturel", or Items 23a or 28a-f show to Madical Exeminar intellibra codified at	ŏ	MD Frederick	Mi	t. Airy						1 ☐ Yes 2√√N
288-	Director	10e. Street and Number	110		10f. Zip Code			10g. Citize	en of What Co	untry?
38 0	۵	13545 A Old Annapoli	a Pood		217	71		Unit	ed Sta	tos
ms 2	Jera	11 Marital Status 12. Was De	cedent Ever in U.S	3. 13. Was		ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No		Race - Amer Black, White	ican Indian,
and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or leams 23a or 28a-f show eumatic event, I'm Medical Examinar must be indiffed at	by Funeral	Armed F 1 Never Married 2 Married 1 Yes, G 3 Widowed 4 Divorced Fear or	2∑No Sive		Yes 2	Specify:	o rican, etc./			ite
atura	Completed	15. Decedent's Education	4	16a. Deceden	t's Usual Occup	ation during most of work	kına		of Business/l	
Bn."n	pie	(Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	life. DO	NOT use retired	daning most or won	w.y		enmount Storage	Moving
Hygien Hygien other th	Con		4	Sale	sman					
d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam				
and Mental I amarked or umatic eve	၉	Edward Joseph St	oesser				a Herric			in Cada
		19a. Informant's Name/Relationship (Type, Print)				and Number or Ru				
m 27		Chari Stoesser Wife	20h Pli	ace of Disposition		Annapolis	Date Date		ation - City or	
rages nent of H int: If ite		20a. Method of Disposition → Burial 2 □ Cremation 3 □ Removal from	n State Ce	imetery, cremati	ory or other plac				·	
tant:		4 □ Dopation 5 □ Other (Specify)				ery Oct.				
permit. Page Department of Important: If any injury or once.		21. Signalure of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that shock or heart failure. List only one cause of	110	Bur	ame and Addre	een Funer	al Home	. & (Cremato	ry, PA
462 * 4		Manual Completions and Completions and	s caused the death	12:	12 W. O	ld Libert	y Road	Winf	ield,	MD 21784 Approximate
	ž.	Julious of mount tanded List only one sales	each line.	. DO HOT BIRDING		/ / / / / / / / / / / / / / / / / / / /	or roophatory a			Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	tecto	e	ion	2				6 445
/Medical Examiner		Due to	o (or as a consequ	ience of):						0
	-	Sequentially list conditions, b.	u (u. as a consequ	ioneo of).						
nsit	Examiner	cause. Enter Underlying Cause (Disease or injury								
al-tra	xar	that initiated events c.	o (or as a consequ	ience of):						
icate be executed physician and s the burial-transit	ai	4 ====								
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es that the death certifigned by the attending be detached for use a	Physician/M		outcome of pregnar		topic pregnanc			2:	3d. Date of del	,
The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	cia	in the past 12 months?	gnant at time of de		ther (specify)	/ 			Month	Day Year
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gned gned	by P	Part II. Other significant conditions contributing to	death but not resu	Ilting in the unde	erlying cause giv	en in Part I.		1		the cause of death?
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aw requ is been 2 should	Completed						24a. Was		24b. Were au	topsy findings availa
The I	E						perfe	ormed?	death?	2 🗆 No
rtifica	a	25. Was case referred to medical				26. Place of Dea				
ysic direc	To B	examiner? 1 Yes 2 No Hospital:	☐Inpatient 2 ☐ E	ER/Outpatient	3□ DOA Ott	ner: 4 🗆 Nursing H	lome 5 Res	idence 6	□Other (Spe	cify)
ng Ph ter th neral			te of Injury onth, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe	how injury	occurred	
Attending Physician: ir death. ector: After this certificaby the funeral director.	Certification:	2 Accident investigation				Yes 2 □No				
after de Directo	tlfic	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At ho Iding, etc. (Specify	me, farm, street	t, factory, office			(Street and own, State)	Number or Ri	ural Route Number,
itel or rs afte ral Dir										
	edical	29a. Certifier 1 Certifying Physician: To to (Check only one) 2 Madical Examinar: On the and me	the best of my know basis of examinat anner stated.	wledge, death o tion and/or inves	ccurred at the ti stigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
ne nospitei n 24 hours a he Funeral C	8				29c. Licen:			29d. Date	signed (Mont	h, Day, Year)
To the Hospitel or Attending Prysician: The tal within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifier		-	0 1 1	11 2 0		1		= 16
o the Hospi within 24 hou To the Funer completely fill	Med	29b. Signature and title of certifier	wi)	44	-1139		\bigcirc	obes	2, 500
To the Hospitel within 24 hours a To the Funeral completely filled	Med	30. Name and address of parent who completed ca	ause of death (Item) 1 23a) (Type, Pri		-11 3 7	0.0	11	bees	5 200
To the Hosp within 24 hou To the Funer completely fill	Med	30. Name, and address of passon who completed ca	T.M.D.	107		narter	- Dr.	Col	imbia	MD 210
S \	tate	30. Name, and address of passon who completed ca	ause of death (Item	107,		narter	- Dr.	Col	imbia	MD 210

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend 23e, per MD g896 10/5/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** ias Olin Stula AM 4c. County of Death J 4: /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Country) 9/ 8. Date of Birth (Month, Day, 5. Social Security Number . last birthday) **Funeral** Months Days Hours Min. 1 M 2 F **214-16-545**2 Usual Residence of Decedent 03-10-1922 MD **Director** filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shov the Medical Exproiner must be notified at 1 ☐ Yes 2 ☐ No Director Windsor MD Ballimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2121 Windsor Garden Ln. Apt. 335c Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ NO Specify: Baltimore, Maryland 21215-0036 Black Specify: 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withil nent of Health and Mental Hygiene. eachers Baltimore C is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be treeman Waters anie ၉ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Words worth Way unif #203 Owings Mills wo ion (Name of Date 20c. Location - City or Town, State Ghee/Daughter 9401 harlene 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ballinge, MD ling Memorial Park 9-22-09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 8728 Liberty Rd. Randalstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and buriat-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. the detached 9 Unknown ģ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No S page ; certificate 2 × No 1 □Yes 1 ☐ Yes To the Hospital or Attending Physician: After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending ours after death.

neral Director: Af
filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIL. 31. Date filed (Month, Year) Registrar's Si State 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 0949 AM 09 26 Smith Kobert 70Q /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Univ. of Maryland Baltimore Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 □ F Days Hours Director 213-62-7588 Dec 6, 1954 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Completed by Funeral Director 1 XYes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 330 South Dallas Court 21231 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □No If Yes, Give Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Black 2 should be filed within 72 hours n and Mental Hygiene. Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Disabled 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William E. Smith Sr. Gloria C. Smith traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any injury or other trau 330 South Dallas Court Baltimore, Maryland 21231 Carolyn Jackson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/01/09 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

1300 Eutaw Place Baltimore, Md 21217

330. Part1. Enter the disease, Thompsications that caused the death. Thompsicate Cause (Final)

Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Bleed /Medical resulting in death) Due to (or as a consequence of): Examiner Consulcoathy Due to finas a linse sume of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed iver cirrhosis P.O. Box 68760, Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy 1 ☐ Yes 2 **N**O 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No in by the 1 Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined n 24 hours after o 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 To the I

3 State 29b. Signature and title of certifier

Samuel 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sanature

Pal

OCT 0 5 2009

DHMH 17 Rev 1/2001

Registrar

29c. License number

1871738741

South Greenz St.

29d. Date signed (Month, Day, Year)

Baltimore MD 21201

09/26/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 30, 2009 **Physician** 3:04 P. M Edith Rose Streett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. Months 1 □ M 2 ff F Hours 214-24-3281 Sept. 16, 1926 Maryland Director 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Weddowl Exanciums to motified at 1 ∐ Yes 3√T√No Director Maryland Harford Pylesville 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 1323 Linkous Road 21132 United States Funeral 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: White <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles M. Burkins Catherine E. Lagan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George A. Streett / Husband 1323 Linkous Road Pylesville, Maryland 21132 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Mem. Gardens 4 Donation 5 Dother (Specify) 2009 Bel Air, Maryland 21. Signatur of Funeral Service Licenses Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, MAryland 21050 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
20 YCLVS Immediate Cause (Final Coronar disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed y physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 50 in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ≥ disease 2 🗌 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy certificate 1 □ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 140 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HeRd Jametsvill, MD 21084 Q Crava

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT

0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar Amend Item 23a per	dŕ.,g897	el tificate of t		Reg. No	3. Time of Death
Physic /Med		BARTUN STE	PHEI		O'C	onth Da	1 2009 6
Exami	ner	4a. Facility Name (If not institution, give street and number Arden Court Assisted L	-	Pil	Location of Death		Baltimore
Funeral Director		263-54-8452 1☑M 2□F	Age (In yrs. last birtho	Months Davs	Hours Min. 8. Da (N Se	ate of Birth Month, Day, Year, pt 10,	9. Birthplace (State or Foreign Country) 1937 Florida
e Maryland Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Carrol1	10c. City, Town o	Finksburg			10d. Inside City Limits 1 □Yes 2 ☑ No
with th		10e. Street and Number 2059 Misty Meadow Roa	d	10f. Zip Code 2104	8		itizen of What Country?
CLICID-UU30 filed within 72 hours after death with the Maryland Hygiene. Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Maxileal Examirer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Yes 2 [If Yes, Give 3 □ Widowed 4 □ Divorced	nt Ever in U.S. s? MXNo	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (Specify Y n, Mexican, Puerto Rican Specify:	es or No- , etc.)	14. Race - American Indian, Black, White, etc. Specify: White
72 hou 72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent's Usual Occup Give kind of work done o	during most of working	16b. i	Kind of Business/Industry
and ZIZIS-0030 be filed within 72 hours aft ntal Hygiene. do other than "natural", or event, it a Malical Evani	Completed	Elementary/Secondary (0-12) College (1-4c	or 5+)	ife. DO NOT use retired Owner			Hardware
ylatic & Vialid & Vialid be filed with Mental Hygis arked other i attic event, it	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Firs		
And years Should be and Mental is marked or raumatic even	2	William H. Stephens 19a. Informant's Name/Relationship (Type. Print)	19b. N	Mailing Address (Street		B. Pin te Number, City	or Town, State, Zip Code)
ore, Maryis s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Suzann M. Stephens Wife		9 Misty Me		inksbur	g , MD 21048 _ocation - City or Town, State
BAIKIMOTE, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important, if item 27 is marked othe any injury or other traumatic event, once.		20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te i	Disposition (Name of crematory or other place L Cremation	Inc. 10/2/0		pstead, Maryland
Dall permit. Departi Importi any inje		21. Signature of Fundal Service Licensee		22. Name and Addre			rstown Road stown, MD 21136
Physician /Medical		23a. Part 1. Enterprise disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or	sed the death. Do no no line. Al	t enter the mode of dyir	ng, such as cardiac or resp		Approximate Interval Between Onset and Death
unificate be executed in graphysician and as the burial-transit	Examiner	cause (Disease or injury that initiated events c.	as a consequence of)				
	ledical	d					
C. DOX he death cer the attendir	Physician/M		h 2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	У		23d. Date of delivery Month Day Year
cords, F. w requires that t been signed by should be detac	5	Part II. Other significant conditions contributing to deat	h but not resulting in t	he underlying cause giv	en in Part I.		o use contribute to the cause of death?
	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No.
	o Be	25. Was case referred to medical examiner? 1 ☐ Yes Hospital: 1 ☐ Inp	atient 2 🗆 ER/Outp	patient 3 DOA Oth	26 At long Home	ck on (6 Dother (Specify)
JIVISION OT VITA I or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification: T	27. Manner of Death 1 Natural 28a. Date of (Month, 2 Accident investigation 3 Suicide 6 Could not be	njury 28b. Tir Day, Year) Inji	me of 28c. Injur	yat k? Yes 2 □ No	Describe how inj	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined 206. Flace of building.	etc. (Specify)	·		City or Town, Sta	te)
the Hosi in 24 ho he Fune	Medical	29a. Certifler (Check only one) Certifying Physician: To the best and manner and manner	s of examination and	or investigation, in my o	ppinion, death occurred at	the time, date a	nd place, and due to the cause(s)
To t with To t com	Z	29b. Signature and title of certifier	M	29c, Licens	e number		e Addy Z, 2009
F		30. Name and address of person who completed cause of BCBMV	2835 Sm	ype, Print)	21209		
S: Regis	tate trar	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of M	arylan		rtment of tificate of		and Mental	Hygien Reg. N	2000	31767
	Physicia			e (First, Middle, Last)		ract p	**			2. Date o	f D - mile	Dav Year	3. Time of Death
	Medic Examin			not institution, give st		EASLE	Y	4b. City, Town, o	or Location o		EMBER 4	27, 2009 tc. County of Death	9:10A M
-)			MARYLAND					CLINTON				GEORGES
	Funeral Director		5. Social Security Nu 217 42 3		7. Ag	e (In yrs. Ia 62	ast birthday) Yrs.	If Under 1 Year Months Days				9. Birth 1946 WASH	place (State or Foreign try) LNGTON, DC
	nd how at	'n	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Loc	ation				1.	10d. Inside City Limits
	Aaryla 8a-f s tified	Funeral Director	MD	PRINCE GE	ORGES	CL	INTON						1 🏋 Yes 2 □ No
	a or 2	iO le	10e. Street and Num					10f. Zip Code			10g. 0	Citizen of What Cour	ntry?
	nth with	ner		RRATTS ROA	D 12. Was Decedent B	From to 116	140.14	207		1-0 (O		ITED STAT	
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married	Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates.		If	Yes, specify Cub	an, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	NO-	14. Race - Americ Black, White, Specify: BLA	etc.
15-0	72 hou "nate edical	Completed	(Spe	15. Decedent's Edu cify only highest grade	ication le completed)		(Give k	ent's Usual Occu ind of work done	during most	of working	16b.	Kind of Business In	dustry
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Maryland	be filed ental Hyg ked oth c event	To Be	17. Father's Name (F						1	er's Name (First, Mid		n Surname)	
aryli	should k and Me is mark raumatic	Ī		me/Relationship (Type	e, Print)		19b. Mailine	a Address (Street				or Town, State, Zip (Code)
	nd 2 st ealth a m 27 is			EASLEY PIN	KNEY / DI	ΓR		JAFFREY				TON, MD 2	
Baltimore,	permit. Page 1 and 2 sh Der artment of Health a Important: If item 27 is any injury or other trai			oosition Cremation 3		C	emetery, crem	sition <i>(Name of</i> atory or other pla AL CEMET		Date 10/02/200		Location - City or To	
Balt	Der art Import any inj once.		21. Signature of Fur	Funeral Service Licensee DONALD R. GRAY 22. Name and Address of Facility ROBERT G. MASON 1 1661 GOOD HOPE RO						FUNERAL ROAD SO	HOME UTHEA	ST WASHIN	IGTON . DC
F			23a. Pa C. Enter the shock, or hear Immediate Cause (F	he disease, or comolic t failure. List only ne	cations that caused	the death							Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)		Due o (or as	a consequ	ence of):						Oliset and Death
-	Examiner	<u>.</u>	Sequentially list cor	nditions, b	Den	ren"	a						
×	ted Insit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying injury	Due to (or as	a consequ	ence of):						
20	cate be executed physician and the burial-transit	E Exa	that initiated events resulting in death) L		Due to (or as	a consequ	ence of):						
200	cate be physic the bu	edical		_ d	l								
88	eath certific attending p		IF FEMALE: 23b. Was decedent	programit	3c. If yes, outcome	of pregnal	ncy	Ectopic pregnan	01/		J.	23d. Date of delive	ery
Box	he death y the atte ched for	Physician/M	in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 Pregnant a 9 Unknown			Other (specify) _	Су		-	Month	Day Year
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rds	require been si	eted	Cran	emic ki	1	913.	eu se			_		-	bably 4 🗆 Unknown
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tal	nysician: The nis certificate I director, pag	BeC	25. Was case referre examiner?							h (Check only one)	es 2 4 1	No. 1 ☐ Yes	2 🗆 NO
Ţ	Physic this or	မ	1 Yes 2 2	INO	ospital: 1 Inpation 28a. Date of inju		ER/Outpatient 28b. Time of		4 ∐ Nu			6 Other (Specify)
o uo	ath. r: After ne funer	icate	1 Natural 2 Accident	5 Pending Investigation	(Month, Day	y, Year)	injury	28c. Inju wor M 1	k? Yes 2	1	oe now inju	ury occurred	
Division	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transicontributed filled in by the funeral director, page 2 should be detached for use as the burial-transicontributed.	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc			et, factory, office			on (Street a Town, Stat	nd Number or Rural re)	Route Number,
	ie Hospit n 24 hour ie Funera bleted fille	Medical	(Check 2	Certifying Physic Medical Examine Certifying Narse	er: On the basis of e	xamination	and/or investi	gation, in my opini	on, death occ	curred at the time, da	ate and plac	ce, and due to the car	use(s) and manner stated.
	To the withing the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the		29b. Signature and t	itle of certifier as	ruks			29c. Licens	e number	6	29d. D	pate signed (Month, I	ated. Day, Year) 27, Dwg May land
	2		30. Name and addre	s of person who cor	mpleted cause of d	eath (Item	23a) (Type, Pr	int)	com.	Rond, For	tw.	ASHINGTM.	May land
	Stat Registra	e	31. Date filed (Month	0 5 2009	32. Registra	ar's Signat	garlo						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 1154 AM **Physician** TSAI OCTUBER MICHELLE 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hookins Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours 1 ☐ M 2 🛣 F Months Days 217-85-3314 Yrs. 7/30/2009 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventret must be notified at once. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 1 ☐ Yes 2 XNo Montgomery Burtonsville Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20866 14549 Almanac Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo If Yes, Give 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Asian þ Specify Specify: 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 0 N/AN/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Yingting Chiu Chengta Tsai ٩ 19a. Informant's Name/Relationship (Type. Print)
Yingting Chiu / Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Almanac Drive, Burtonsville, MD 20866 14549 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/5/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Servcies 21. Signature of Funeral Service Licensee " larston Donete PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or es e consequence of): Examiner MMUNDDEFICIENC DNGENITAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and Box 68760 Due to (or es e consequence of): Be Completed by Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 Mo Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2, XNo 1 XYes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Machine Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 05 2009

NITZUL

WD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOCKMAN

29c. License number

RES-000

600 North Wolfest, Bathmore, MD 21287

29d. Date signed (Month, Day, Year)

2009

OCTOBER

Lester JAMES WILLIAMS 09-07428 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day Y September 22, 2009 0823 hrs Medical Examiner James 4c. County of De 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Baltimore Sinai Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Min Months Days Hours Director 43 Country) 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show more Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 161 Funeral 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes If Yes, Give Year Yes 2 No specify: Specify: Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) d Mental Hygiene. s marked other than "n ic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sister If item 27 is m her traumatic 20b. Place of Disposition (Name of cometery Baltimore, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 12/2009 Other Specify comator Donation 5 22. Name and Address of Faul Joseph L. Russ Fi 2222 W. North Ave 21. Signature of Funeral Service Licenses tunera Part I. Enter he disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart eilure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death a Cocaine intoxication and narcotic use Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Jause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a,27,28a-f,perME, G896 10/6/09 TT X UNPENDED ed by the attending physician detached for use as the burial -AMENDED requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? 2 No certificate ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes No After 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Yes 2 X No Natural 5 Pending unknown Director: d in by the f within 24 hours after death.

To the Funeral Director: Fd 9/22/09 Fd 7:50 am 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. found in front of a closed (Specify) firehouse 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3500 Woodbrook Ave Baltimore, MD 3 Suicide Could not be filled determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number September 23, 2009 O.C.M.E. Elle 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

Assistant Medical Examiner

32 Registrar's Signatur

Victor Weedn MD JD

31. Date filed (Month, Day, Year) 2009

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		•	for State Registrar	State of M	•		ent of Heal ate of Deat			giene Reg. No.	009	31770		
	Physicia		1. Decedent's Name (First, Middle,	· ·	nand Wri	iaht			2. Date of Dea Month	Bep 28, 2	Year	3. Time of Death 7:50 a M		
	Medic Examin		4a. Facility Name (if not institution,	give street and number)			City, Town, or Locat				ounty of Death			
کمبر	Funeral				spice Care e (In yrs. last birthe			Town	8. Date of Birt		Baltin 9. Birthp			
	Director		213-64-2809 Usual Residence of Decedent	1 □ X M 2 □ F	54 Y	rs. Mon	ths Days Hou	urs Min.	(Month, Day Mar 1	4 Year) 0, 1955	Topont	lace (State or Foreign		
	land show dat	tor	10a. State 10b. County		10c. City, Town	or Location								
	r 28a-1 notifie	Direc	Maryland 10e, Street and Number	N/A		Baltimore						1 Mres 2 □ No		
	with th	Funeral Director	6112 Marlora Road					21239		tug. Citizen	of What Count U.S.A			
	e filed within 72 hours after death with the Maryland ttal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Decedent E Armed Forces?		13. Was D If Yes,	ecedent of Hispanic specify Cuban, Mex	o Origin? (Spec kican, Puerto F	cify Yes or No- Rican, etc.)		Race - America Black, White, e			
55	urs afte ural", c I Exam	ted by	3 Widowed 4 Divorced	1 Yes 2 X If Yes, Give Year or Dates.	NO	1 □ Y	es 2. Ox No Spe	ecify:		Spe	ecify:	Black		
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o Î	and 2 Health em 2 ther t		Sheila Wright 20a. Method of Disposition		20b. Place of I		Marlora Roa	_	re, Marylan		ion - City or To	un Stata		
Ē	Page 1 nent of ant: If it ury or o		1 🕱 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		cemetery,	, crematory	or other place) emetery & Ch		10/03/09	20c. Local	Baltimore			
Baltimore,	permit. Page 1 Department of Important: If it any injury or o	j	21. Sign vire Funeral Servic i	e and Address of F	acility	al Service	PA							
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·	hysician/	8 0	Immediate Cause (Final disease or condition	_ a _ Co w	oplica.	tion	s of	Lung	Can	cer		Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a	a consequence of):		7	F.					
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200	certifica nding p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					23d	. Date of deliver	rv		
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0 00	nding 1 ath. r: After e funer	icate	1 Natural 5 Pending 2 Accident Investige		ry 28b. Tir (, <i>Year</i>) inju	ne ot ury M	28c. Injury at work? 1 ☐ Yes		8d. Describe h	ow injury oc	curred			
DIVISION OF VITAL RECORDS,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		ıry - At home, farn	n, street, fac	etory, office	2	8f. Location (Si City or Town		ımber or Rural I	Route Number,		
2	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, de	eath occure	d at the time, date a	and place, and	due to the cau	se(s) and m	anner as stated			
	the Hi thin 24 the Fu	_ ((Check 2 ☐ Medical Exonly one) 3 ☐ Certifying 129b. Signature and title of certifier	aminer: On the basis of each of the Nurse Practioner: To the	kamination and/or i best of my knowled	dge, death o	ccurred at the time,	date and place	, and due to the	cause(s) and	d manner as sta	ted.		
	F > F 8		1	Jut CRNI	0		29c. License numb			septu	gned (Month, D	-8, 200 9		
	7		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Ty	pe, Print)	t. Tou		4.1	2 /	204			
	Stat	е	31. Date filed (Month, Day, Year) OCT 0 5 2003			Kel	1 184	1300,	una	,	7			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink	Ensure All Copies Are Legible.
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		For Stata Registrar	State	of Marylar			nt of H te of L		ind M		jiene leg. No.		31771
Physicia		Decedent's Name (First, Middle Edward	Last)	Willi	.ams			_		2. Date of Dea Month Septem	Day		3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, Greater Balti			Center			Location o	of Death		4c.	County of Death	1
Funeral Director		n/a	6. Sex 1X□M 2□F	7. Age (In yrs.	last birthday) Yrs.	Months 0	er 1 Year Days	Hours 3	Min. 51	8. Date of Birth (Month, Day 9-26-20	Year)	Co	nplace (State or Foreign untry) 1 Land
ith the Maryland or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltin	nore	10c. Ci	ity. Town or Loc		1s						10d. Inside City Limits 1 ☐ Yes 2 No
after death with the Maryla or itams 23a or 28a-f shor minet roust be politied at	ai Director	10e. Street and Number 1 Aspen Glen Cou	ırt			10f. Z	ip Code 2111	7			-	zen of What Co ted Stat	,
	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F	2 X No ive	H	Yes, sp	edent of Hi ecify Cuba 20 No	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: B	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; any injury or othar traumatic event, the Modical Exe once.	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	grade completed,) (1-4or 5+)	16a. Deced (Give life. L	kind of w OO NOT	rork done d use retired	ation during most	of working	g		ind of Business/	ndustry
utd be fited Vental Hygi rrked other rtic event, I	To Be Co	17. Father's Name (First, Middle, L Gary Williams	ast)			•			r's Name ımika	(First, Middle,		Sumame) McGusty	
and 2 sho lealth and 1 m 27 is ma			ip (Type, Print) (Father)	1205	1 Asp	en G	len C	ourt	Owin	gs Mill	Ls,	m Town, State, 2	7
t. Pages 1 tment of H tant: If ite		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp	ecify)			rema	tion,	Inc.	10-	and the second second	Ham		Maryland
permit. Departr Imports any inj			J. Wayne		ing EL	INE	FUNER	SAL HC	ME	Reister	csto	terstown	21136
Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	_ as	SEVERE	RESP	i RA	TOLY	ACU	DOS	respiratory ari	rest,		Approximate Interval Between Onset and Death
Examine the executed physician and the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-transit the burial-trans	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to	(or as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of as a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a consection of a conse	RISP(RA	DEY	De	STE	BS SY	WDO	LENK	4 Hes
attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live	utcome of pregn birth 2 Peta nant at time of a nown	al death 3 🗌	Ectopic Other (s	pregnancy specify)					23d. Date of deli Month	very Day Year
quires that the d	þ	Part II. Other significant condition	PLEMAN	death but not res	sulting in the un	derlying	cause give	en in Part I.		23e. Did to			the cause of death?
	Completed			· · · · · · · · · · · · · · · · · · ·						24a. Was a autop perfor	sy	prior to death?	topsy findings available completion of cause of 2 No
this ald	n; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2 [of Injury	ER/Outpatien	3 🗆 🖸	OCA Other	er: 4 □ Nui	rsing Hon	(Check only or ne 5 ☐ Resid	ence	6 □Other (Spec	city)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ation of be 28e. Plac	e of Injury - Ath	Injury nome, farm, stre	M eet, facto	10	Yes 2 □ N		8f. Location (S City or Tow	Street an m, State	d Number or Ru	ral Route Number,
the Hospital in 24 hours a the Funeral E	edical Ce	29a. Certifier 1 Certifying (uneck only one)	Physician: To the xaminer: On the i	e best of my kno casis of examina nner stated.	owledge, death ation and/or inv	occurre	d at the tim on, in my op	ne, date and pinion, deat	d place, a	nd due to the o	ause(s)	and manner as place, and que	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	Irem			2	9c. License	number	560		29d. Dai	te signed (Monti 26 09	h, Day, Year)
		30. Name and address of person w	GENIC	6701	N. CHAN	Print)	ST	EAL	Timo	RE, Pl	0_	26.09	
Sta Registr		31. Date filed (Month, Day, Year)	9 /32.1	Registrar's Sign	ature bark	1				(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#29c per DVR G896 10/5/09 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Rose Liem 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shewi rail haren 14,10 If Under 24 Hrs. Birthplace (State or Foreign Country)
 MI If Under 1 Year 8. Date of Birth (Month, Day, April 29 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 ₩ 2 □ F Yrs. 384-28-8432 80 1929 Director Usual Residence of Decedent of 2 should be filed within 72 hours after death with the Maryland thin and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, n. "feates Ensign traumatic event, n. "feates Ensign traumatic event, n. "feates Ensign traumatic event, n. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 □Yes 2 🙀 No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Myes 2 No
If Yes, Give
Year or Dates: Korea 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify. Specify: ģ White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Patent Attorney permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Ziems Ruth (Unknown) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2246 Mohegan Drive Apt. 204 Falls Church, VA 22043 Mr. Robert N. Ziems (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial X ☐ Cremation 3 ☐ Removal from State All County Cremation 10/3/2009 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 Haist MOO 764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac **Physician** arres /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) (unce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi P.O. Box 68760, 5 attending physician and for use as the burial-trar Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an cate has page 2 s autopsy performed? Yes 2. No this certificate 1 □ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10.4.09 D68966 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7200 Third Ave. Sykesville, 40 enderion

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Physicia /Medic Examin	ć
Funeral	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a five Jical Examination must be notified at once.

Baltimore, Maryland 21215-0036

Physiciar /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regis

	1 - State Registrar	C	Certificate of	Death	F	Reg. No.	
	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	nth Day Yea	3. Time of Death
cian Iical	Nathan Gordon	Butter	field		Sept_		9 2:32 a M
iner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	
	Prince George's Hospital	L	Cheve	erly		Prince	George's
al	5. Social Security Number 6. Sex 7. Age	(In yrs. last birtho	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h 9. B	irthplace (State or Foreign Country)
r	5/8 /0 6242	56 Yrs	S. ,		Dec 28	,1952 Wa	sh., DC
	Usual Residence of Decedent 10a, State 10b, County	Oc. City, Town o	r Location				10d. Inside City Limits
ō		vashing					1√2 Yes 2 □ No
lec.	10e. Street and Number		10f. Zip Code			10g. Citizen of What 0	Country?
ā	1425 N. Street NW #811		200	005		US	, oa, .
Jera	11. Marital Status 12. Was Decedent Ev	er in U.S.	13. Was Decedent of H	ispanic Origin? (Spe	cifv Yes or No-	14. Race - An	nerican Indian,
Ē	Armed Forces? 1 ★ Never Married 2 Married 1 ★ Never Married 2 No If Yes, Give		If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wh	
2	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup	ation		16b. Kind of Busines	s/Industry
g	Elementary/Secondary (0-12) College (1-4or 5+)	- li	fe. DO NOT use retired	1)	'g	 .	
ြင်	1201	Ма	intenance			Priva	.te
Be	17. Father's Name (First, Middle, Last) Unknown			18. Mother's Name Delores		,	
ြု					Grave		
	19a. Informant's Name/Relationship (Type. Print) Drusilla Nelson/sister		lailing Address (Street			· -	
	20a. Method of Disposition		5 14th St		#2 Wa	20c. Location - City of	
	1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State		isposition (Name of crematory or other plac			•	,
	4 □ Donation 5 □ Other (Specify)	Riverda	le Park Cre			Riverdale	
SAILX.	21. Signature of Funeral Service Licensee	W 901					ERAL HOME
	23a. P 11. Enter the dis e, or complications that caused the						, MD20601 Approximate
	smock, or heart failure. List only one cause on each line.	e death. Do not	enter the mode of dyin	g, such as cardiac o	r respiratory an	rest,	Interval Between Onset and Death
	resulting in death)		llation				
	Due to (or as a c	consequence of):					
ē	Sequentially list conditions, b. Acute	Perica					
Examiner	cause. Enter Underlying	. ,	atory Fai	luro			
Exa	resulting in death) Last C. Due to (or as a control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro	consequence of):		Ture			
	d.						
Medical							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2	pregnancy	2 D Estenia programa			23d. Date of d	elivery
Completed by Physician	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		Month	Day Year
Ę,	9 Li Unknown						
P P	Part II. Other significant conditions contributing to death but	not resulting in the	e underlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
fed					1 🗆 Y	es 2 No 3	Probably 4 🔀 Unknown
lg e					24a. Was a	an 24b. Were	autopsy findings available completion of cause of
5					perfor	med? death'	es 2 🗆 No
Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only or	ne)	
	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 □ X ER/Outpa	tient 3 DOA Othe	er: 4 🗆 Nursing Hon	ne 5 🗆 Resid	ence 6 □Other (Sp	pecify)
on:	27. Manner of Death 28a. Date of Injury 1 Natural 5 □ Pending (Month, Day,)	(ear) 28b. Time Injur	e of 28c. Injury ry Work	/ at 2		ow injury occurred	
cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 29a Bloom of Injury			Yes 2□No			
Certification: To	4 Homicide determined 28e. Place of Injury building, etc.	 At home, farm, 'Specify) 	street, factory, office	2	8f. Location (S City or Tow	treet and Number or i n, State)	Rural Route Number,
ပိ	29a. Certifier XXCertifying Physician: To the hest of	nu knewleder	enth one and the second	and date in the			
Medical	29a. Certifier Check only one) 2 Medical Examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner.	camination and/o	eath occurred at the tin or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the o ed at the time, o	cause(s) and manner date and place, an <mark>d d</mark> i	as stated. ue to the cause(s)
Mec	29b. Signature and title of certifier	4.1	29c. License	e number	2	29d. Date signed (Mor	nth, Day, Year)
	1 alice oran		J 7-	7 ())		9/12/-	0 0
	30. Name and address of person who completed cause of dear	h (Itam 22a) (Tu	De Print)	10//		1110/1	7
	Ophnell Cumberbatch, M		1 Hospita	1 Drive	Charre	rla Mr 2	7705
ate	31. Date filed (Month, Day, Year) 32. Registrar's		. mospita	т рттле	cheve	LTA'MD 70	J / O D
trar	SEP 2 1 2009 Janear	1 A	backer				

			FOR	partment of Health and N	Mental Hygie	ene	0177
			Registrar	ertificate of Death	Reg. 2. Date of Death	. No. 🔬 📗 🖰	3. Time of Death
П	Physici	an	1. Decedent's Name (First, Middle, Last)		Month	Day Year 2009	2:22P M
Ç.,	/Medi		PEGGY JUNE BROOKS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	SEPTEMBE	4c. County of Death	Z: ZZP
	Examir	ier	4010 KELKRIS CIRCLE	HURLOCK		DORCHES	TER
	Funeral	9	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign
	Director		267-60-1380 1□M 2ÅF 68 Yrs	Months Days Hours Min.	JULY 7,	1941 ALAE	BAMA
١٦	pur w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		1	10d. Inside City Limits
5	laryla shor	5	MARYLAND DORCHESTER HURL				1 ☐ Yes 2 📉 No
Z	the N 28a-i	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cour	ntry?
3	3a or	Ö	4010 KELKRIS CIRCLE	21643		USA	
1	ms 2: mus	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	
9	after or ite	큔	Armed Forces? 1 □ Never Married 2 🖾 Married 1 □ Yes 2 🛣 No 1 € Yes, 6 ive	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Hican, etc.)	Black, White,	
03	ral", Exar	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Till res Zin No Specily.		Specify: WI	HITE
5-0	72 h "natu dicai	etec	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	king 16	b. Kind of Business/In	dustry
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifited at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	1EMAKER		OWN HOME	Ξ
	filed v Hygie other		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
Maryland	d d d	To Be	JOHN MOSS	DORIS	McCANN		
ary	2 should and Men is marke	-	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ailing Address (Street and Number or Ru	ral Route Number, C	City or Town, State, Zip	Code)
	1 and 2 Health em 27 i		·	010 KELKRIS CIRCLE,	HURLOCK	MD 21643	
ore	of Heritter		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Discemetery, or	sposition (Name of crematory or other place)	Date 20	c. Location - City or To	own, State
Baltimore,	Pages treent of I tant: If its jury or o		4 □ Donation 5 □ Other (Specify) EAST NEW	MARKET CEM. 9/19/	²⁰⁰⁹ EA	AST NEW MAI	RKET, MD
Bal	permit. Pages Department of important: If it any injury or once.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility ZELLER FUNERAL HOM 106 MAIN_STREET, E	IE P. O. LAST NEW M	BOX 207 IARKET MD 2	21631
O.			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	MYOCARDIAL	- INFAR	CTION	Ho YRS
Fig.	/Medical Examiner			EROTIC CARDIOU			
н	LAGIIIIICI	_	Sequentially list conditions	STULL CHEDION	MSCULM	ik idistase	YEARS
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury				
	ate be executed obysician and the burial-transit	Examiner	that initiated events c				
8760,	icate be ex physician s the buria	dical E					
687	ficate phys	edic	0				
Вох	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of deliv	ery
	death e atte	icia	in the past 12 months? 1 Ves 2 No.	3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>		Month	Day Year
P.0	that the died by the detached	hys	9 ☐ Unknowh			1	
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	5	Part II. Other significant conditions contributing to death but not resulting in the	NA .		cco use contribute to t	
ord	sen s	Completed	METHSTATIC IS DEAST CANCEL		1 ☐ Yes	2 <mark>78</mark> No 3□ Pro	bably 4 □Unknown
ec	as b	nple	MYELOMA, HEDATITIS C. T.	DIABLIED	24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
E	: The cate I	S	SEVERE RHELIMATOID A'R	THRITIS	performe	death? No 1 ☐ Yes	2 No
Vit	ician certifi ector	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other:	th (Check only one)		
9	Physician: r this certific ral director,	۲:	1 ☐ Yes 25 No	tient 3 DOA Other: 4 Nursing H	ome 5 🔀 Residen	ce 6 Other (Speci	fy)
Division or Vital Records,	ding h. After fune	tion	1. Natural 5 □ Pending (Month, Day Year) Injur 2 □ Accident investigation		Zod. Describe now	injury occurred	
S	i or Attending after death. Director: After	fica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm,			et and Number or Rur	al Route Number,
Οį	al or safter	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch				
	the Ihin 24 the F	Medical	one) and manner stated. 29b. Signature and Me of certifier	29c. License number			
	Sor With	_	Ma Mahb Angana M	D00530	CII	I. Date signed (Month,	0 9

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Ye ar PM anche ember 13 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cambride Chester General Hosp: tal
Number 6. Sex 7. Age (In yrs. låst birthday) Dorchester 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F **Funeral** Months Days Hours Min. Director Maryland Usual Residence of Decedent hours after death with the Maryland 10c. City, Town or Location 'natural", or items 23a or 28a-f show 10d. Inside City Limits the Medical Examinar must be notified at 1 Yes 2 No **Funeral Director** Jorchester 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. College (1-4or 5+) Seafood Industry is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ injury or other traumatic reorge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 Is
any injury or other trau Lexington Par KMD, 20653
Date Joc. Location - City of Town, State 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cemetery Cambridge, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Henry Funeral Hone, P.A.

23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sente **Physician** SLOCK /Medical Due to (or as a consequence of): Examiner Failure Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed s certificate has b lirector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 2 No 1 ☐ Yes the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 No atter death Director: Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 047924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 CAMBRIGAE NOME THANW 3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Registra AMEN#20b+openFH, 9-22-09, BWW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 09 09 19:27 M Lusephine 6 /Medical Feality Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number Mal Wester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 13, Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 2 ☐ **x**F 1947 62 069-36-8347 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1X Yes 2 □ No Germantown MD Director Montgamery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20874 U.S.A. 12201 St. Peter Court Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ∐Yes 2 1 No Specify. Black Specify: ð 3 ☐ Widowed 4 ☑ Divorced 'natural' Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery Co than College (1-4or 5+) 2 yr Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Public Schools yr Para Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h Joseph Edwards Kitty Banks မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once. 12201 St. Peter Court, Germantown, MD 20874 Joi Botchway (Daugnter) 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery crematory or other place) te of Heaven Cemetery 1 Souls Cemetery Silver Spring, MD 11 Burial 3 Removal from 4 Donatig 5 Other (Specify) 9/26/09 Germantown, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. eral Service Licenses 246 N. Washington St, Rockville, MD 20850 that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a operach line. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Disseminated disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed Veerchzing physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐Yes 2 🗷 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 7 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No hours after death. 2 Accident filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier 1 [[] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 1619138013

Registrar
DHMH 17 Rev 1/2001

State

30. Name and

31. Date file

Creene St Ball.

(Item 23a) (Type, Print)

Registrar's Signature

dress of person who completed cause of dea

usit

Year)

2

(Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For Amend Ite	State of Marylandems 25,27,28a-f	per i	artment of ne , g898, rtificate of	Health a 12/18/0 f Death	Mental Hy	giene Reg. No.	9 3177
			Decedent's Name (First, Middle, La					2. Date of De Month		3. Time of Death
	Physici /Medic		Mildred Pauline	Bostetter				septem!	per 19 200	9 4:32 PM
	Examin		4a. Facility Name (If not institution, given			4b. City, Town,		f Death	4c. County of Dea	
			Washington County			Hagerst		Miles I a Day (Dis	Washingto	
	Funeral		5. Social Security Number 6. \$ 213-24-9714	Sex 7. Age <i>(In yrs. l</i> e 1 ☐ M 2 X F 93	a <i>st birthday)</i> Yrs.	If Under 1 Yea Months Days		Min. (Month, Da	ay, Year) 9. Bi	rthplace (State or Foreign Country) Vland
	Director		Usual Residence of Decedent	93				Sep. 2	,1916 Mar	yrand
	yland		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	용	Maryland Washing	ton County Wil	liams	port				1 X Yes 2 □ No
	or 28	Dir.	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Madisal Examinar court be mutified at	Funeral Director	154 N. Artizan S			2179			U.S.A.	- vices Indian
	er de	٦	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 [Y]No	5. 13.	Was Decedent of If Yes, specify Cu	t Hispanic Orig uban, Mexican,	gin? (Specify Yes or No , Puerto Rican, etc.)	o- 14. Race - Am Black, Wh	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1∐Yes 2∭[N	lo Specify:		Specify: W	Mite
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occ	cupation	6 state o	16b. Kind of Busines	s/Industry
218	thin 7 e. an "n	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work don DO NOT use reti	red)	or working		1
	filed withii Hygiene. ither than	S	8		Home	emaker	T	(5) 14:10	Personal F	Residence
nd	be fill d off even	Be	17. Father's Name (First, Middle, Last	")			· I	r's Name <i>(First, Middle</i> a K. Justic		
Maryland	d Mel narke	မ	William S. Coss	(Time Brief)	10h Maiii	na Addresa /Ctro			per, City or Town, State	Zin Code)
Ma	d2sh than t7 is r traur		Joan E. Keener-da	, , ,					stown, MD 2	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "witsal Experime cuttal be notified at		20a. Method of Disposition			osition (Name of matory or other p		Date	20c. Location - City of	
OL	ages ent of nt: If I		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	_ Hemoval from State		en Cemete	i -	9-24-2009	 Hagerstown	Maryland
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Lice						. Fiery Fu	
ä	Depar Impor any Ir		Dunkon 1	V King	- 1				lagerstown,	
			23a. Part 1. Enter the sease, or one shock, or heart filure. List only	plication that cau d the death	. Do not en	ter the mode of d	lying, such as	cardiac or repiratory a	arrest,	Approximate Interval Between
مي	Physician		Immediate Cause (Final disease or condition	randi	Va:	scule	ro	9/14031	- /	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		2 /	,		4
	Examine	ايرا	Se wentially list conditions,	b. respir	210	nyt	zilvi	~	1	Thorn,
	ted nsit	nine	Se ventially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence on.	Ĺ		10	- VARINER	
	execunand al-tra	Examine	that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):			APPROVED BY MEDICA	EXAMINE	
8760,	cate be executed physician and the burial-transit			d .			CERTIFIC TION	♠ Win		
9	tificat ng phy as th	Physician/Medical								
Вох	death certific e attending p d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal		☐ Ectopic pregna	ancv		23d. Date of c	
O. E	0 0 0	sici	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnant at time of do		Other (specify)			Month	Day Year
P.	The law requires that the do ate has been signed by the bage 2 should be detached	Phy	9 ☐ Unknown ➤ Part II. Other significant conditions	contributing to death but not recu	Iting in the u	inderlying cause	given in Part I	23e Did	tobacco use contribute	to the cause of death?
ds,	ires tl signe d be d	þ	and memorial	contributing to death but not resu	iting in the c	inderlying cause !	giveniiii atti			Probably 4 ☐ Unknown
Records,	w requir been s should	Completed	12 Starain	hametom.	1	mana	101/2	24a. Was	24h Word	autopsy findings available
Re	The law cate has page 2.	Ig I	7577 9001	Terrain /	10			/ auto	opsy prior to death	o completion of cause of ?
Vital			25. Was case referred to medical	Vascule - De	ars o	ntic	26 Place	1 ☐ Yes of Death (Check only		es 2 No
<u>></u>	Physician: this certific al director, I	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 □ DOA	Mhor:		sidence 6 ☐ Other (Si	pecify)
اه ر		ii.	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o				how injury occurred	
<u>Ö</u>		atic	Accident 5 Pending investigation	on Unknown	Unkno	NIIM 1	□Yes 2X	No Unkn	own	
Division	al or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		me, farm, st	reet, factory, offic	e	City or To	(Street and Number or own, State)	Rural Route Number,
	urs af eral D		00- Continue 4570 attains	Unknown		N	. Para data a	Unkn		an atatad
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 ✓ Certifying P (Check only one) 2 Medical Exa	thysician: To the best of my known miner: On the basis of examinat and manner stated.	wieuge, dea tion and/or ii	in occurred at the nvestigation, in m	e ume, date an ny opinion, dea	id place, and due to the ith occurred at the time	e, date and place, and d	ue to the cause(s)
	Fo the Vithin 2 the Somple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number		29d. Date signed (Mo	nth, Day, Year)
	17			mon	/	mx	D30	975	9/22	109
	-		30. Name and address of person who					./	4	
			<- 1 m	524 (00 D	. 24	8Mill	15+	+146-16	Laura M	0 20247

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 7.8 Maryand 18896 10-5-09 eath and Mental Hygiene

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Secondary States Prederick Frederick		Physicia	ın	1. Decedent's Name (First, Middle, Last)		3. Time of Death 10:50 Рм							
College View Center Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Frederick Fredrick Frederick Frederick Frederick Frederick Frederick Fredrick Frederick Fredrick Frederick Frederick Frederick Frederick Frederick Fredrick Frederick Frederick Frederick Frederick Frederick Fredrick Frederick Fredrick Frederick Frederick Frederick Frederick Frederick Fredrick Frederick Frederick Frederick Frederick Frederick Fredrick Frederick			4a. Facility Name (If not institution, give str	4b. City, Town, or	Location of Death		4c. County of Death						
19.4 - 38 - 30.0	فحرم								R Date of Birth				
100. Early 100. Courty 1				194-38-3004 1X					July 28,	1948 Penns	sylvania		
198. Mailing Address (Siroet and Number or Fusual Route Number, City or Town, State. Zip Code) Patricia L. Parlett / Friend 123 East 8th St. #108, Frederick, MD 21701 20a. Method of Disposition 11		land ow			10c. (City, Town or Lo	cation			1	0d. Inside City Limits		
198. Mailing Address (Siroet and Number or Fusual Route Number, City or Town, State. Zip Code) Patricia L. Parlett / Friend 123 East 8th St. #108, Frederick, MD 21701 20a. Method of Disposition 11		Mary a-f sh	ctor	Maryland Frederick Frederick							1 Yes 2 No		
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198. Mailing Address (Siroet and Number or Fusual Route Number, City or Town, State. Zip Code) Patricia L. Parlett / Friend 123 East 8th St. #108, Frederick, MD 21701 20a. Method of Disposition 11	15-00	n 72 hou "natura	oleted	15. Decedent's Educa (Specify only highest grade of	tion completed)	I 16a Dogge	dent's Usual Occup kind of work done o	eation during most of world)	king	16b. Kind of Business/In	dustry		
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	To the Hospitel or within 24 hours after To the Funeral Dircompletely filled in	Medical	one)	xaminer: On the basis of and manner sta		on and/or	investigation, in my op			· · · · · · · · · · · · · · · · · · ·			
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•	51		30. Name and address of person w	no completed cause of c	leath (trem :	23a) (Typ		717064	10 16		11	2 (2)/	
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	Registr	ar	OCT 0	5 2009 Len	we	B.	parker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 29a, DOR, 9/23/09, LDB Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** Erice Cornish Wayne 0110 20,2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Year If Under 24 Hrs Salisbury Rehabilitation e Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2□ F Months Days 217-52-0456 59 Director Maryland Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan har frust be notified at any injury or other traumatic event, the Medical Evan har frust be notified at any once. 10b. County 10c. City, Town or Location 1 ∰es 2 □ No Director Sbur NICOMICO 10g. Citizen of What Country? 10f. Zip Cod 10e. Street and Number 215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 PNo Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) en sed Practical Norse Health 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Camper ornish -illian ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type: Print) Aloma Sbury /MD. 2 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/25/09 Cambridge, Midshore Cremation 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNERAL HOME) MD-21613 washington St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mouth disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or a a consequence of signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) CRNP 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 200

State Registrar

31. Date filed (Month, Day, Year)
SEP 23 2009

30. Name and address of person

Registrar's Signature A. Solisbury and 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician VIIV. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner anne arundel CAME Andel Medical Center Annapolis Birthplace (State or Foreign Country) Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Months Days 1**⊠**M 2□F 052-58-2582 09-08-1960 Bronx NX Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 28a-f show d other than "natural", or Items 23a or 28a-f show event, the Medical Examina must be notified at 1XYes 2 No Director Hanover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Noilf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ۵ Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, The Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brcker INsurance Inducto 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Althor Landrum Daniel Crawford ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1442 Freddwina Kax Boulder LN Crawford Hanover MD (Wifel 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crematory Riverdale 09-21-2009 4 ☐ Donation 5 ☐ Other (Specify) 814 upshur St N.W 21. Signature of Funeral Service License 22. Name and Address of Facility Washington DC. 20011 u Services Nac Approximate Interval Between Opset and Death 23a, Part 1. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ne cta Carcinoma O months **Physician** a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☑ No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 31. Date filed (Month, Day, Year) 22 SEP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D57078

29d. Date signed (Month, Day, Year)

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland		rtment of H tificate of i			450	000	() 1 **	0.0
	-	-	1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death									Death	
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	/Medic Examin	.3	OCCUPATION OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DESIGN OF DE										
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 12 Yes 2 1 If Yes, Give Year or Dates:	10/	.2-	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☑ No	ispanic Origin? (Span, Mexican, Puerti Specify:	pecify Yes or No Bican, etc.)		I. Race - Ameri Black, White Specify: Wh		
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Mary	nd 2 sho lith and I 27 is ma r trauma	i s	19a. Informant's Name/Relationshi Nicholas Barbell				ng Address <i>(Street</i> Hunter M					ïp Code)	
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	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 2 2		rar's Signat	far	KI						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ma'Niyah **Physician** Ijea Carraway A^{M} September 8, 2009 1:19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours Director None 20 2009 Maryland Sept. 8, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11758 Carriage House Drive United States 20904 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Meeko Carraway 2 Shane1 Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shanel Hill/Parent 11758 Carriage House Drive; Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 9/21/09 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 1040 Rockville Pike; Rockvil EXTREME PREMATURITY 1040 Rockville Pike; Rockville, MD 20852 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any county to the cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a ponsequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical nding pure IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has the rector, page 2 s autopsy performed Yes 2 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this : After this funeral c 27. Manner of Death 1 XNatural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death Director: / 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Discompletely filled in certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

HELMBRECHT, MO, 9901 MEDICAL CENTER DRIVE, ROCKUILLE, MARYLAND 20850 31. Date filed (Month, Day, Year) SEP 22

22. Registrar's Signature

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0059166

WCHD/SC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0215 AM SEPTEMBER Kwan Sun Cheung 19 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year May 11, 19 9. Birthplace (State or Foreign **Funeral** Days Months Hours South Korea 1 X M 2 □ F 216-25-7121 48 1961 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Wedgal Examinating at 1 ☐ Yes 2√☐ No Director Baltimore Cockeysville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 611-K Crambrook Road 21030 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Asian Specify: <u>6</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Stall Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Farmers Market Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental marked o of the and Ments

27 Is marked

traumatic ex Jong Hwan Cheung Jung 0ck Beck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other traconce. Song Sook Cheung 611-K Crambrook Road, Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 09-21-09 |Hagerstown, Maryland 4 Donation 5 □ Other (Specify) Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, hagerstown, 21. Signature of Funeral Service Licensee -R. hoel Brad Md. 21740 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** preumonia /Medical Die to (or as a consequence of): Examiner 4 microbicl Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed physician and the burial-transit postone humaninese Due to (or as a consequence of): Box 68760, Physician/Medical After this certificate has been signed by the attending p tuneral director, page 2 should be detached for use as i IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No spital or Attendi lours after death. neral Director: A death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

UNION HEMORIAL HOSPITAL, 31. Date filed (Month, Day, Year) SEP 2 1 2009

6000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29b. Signature and title of certifier

201 32. Registrar's Signature Jak

29c. License number

EAST UNIVERSITY

AU4176435019843

Pruy.

29d. Date signed (Month, Day, Year)

SEPTEMBER 19 2009

BALTIMORE, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Month **Physician** Sarah Lydia Dayton September 50 M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6. Sex 7. Age (In yrs. last birthday) WICOMICO ninsula 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year **Funeral** Year) 1 □ M 2 🕇 F Months Hours Davs Yrs. 93 Aug. 6, 1916 Director 217-10-8460 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location MD Wicomico Mardela Springs 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 212 Bridge Street 21837 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white \$ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) garment seamstress 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Vickers Emily Spedden 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randall Hughes 23683 E. Hurley Neck Rd, Mardela Springs, MD 21837 p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 9/22/09 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. - u T-lens 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ventriculas **Physician** /Medical Due to (or as a consequence of): **Examiner** ANI Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Days. The law requires that the death certificate be executed Due to (or as a consequence of): and burial-trar attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fun Arthistensis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed Stan Done Chroni Kidny 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Pwithin 2

P.O. Box 68760,

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

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29c. License number

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29d. Date signed (Month, Day, Year)

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	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No.	19 31737
Physician /Medical	Joseph Martin Dickerson 2. Date of Death Month Day September 19 a	Year 2009 1450 P
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State Registrar	AHBUBA AUHTER, 503 Dyfen Strut, Camberdy 1. Date filed (Month, Day, Year) SEP 22 2009 Lever B. Daris SEP 22 2009	MO-21613

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المريد ب	/		Annapolitan Assisted Livi	ing	Annapolis	5	_	Anne	Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. 1 M 2 1 F 7.	Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year If Un Months Days Hou		8. Date of Birth	9. B 31 Ne	orthplace (State or Foreign
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	ryland -f sh	ctol	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 Yes 2 No
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 3 🏋 Widowed 4 ☐ Divorced Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	IX No	f Yes, specify Cuban, Mex 1 □ Yes 2 🕅 No Spe		ican, etc.)	Black, Whi	te, etc. White
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≥,	nd 2: lealth m 27 her tr		Lorie A. Carr/ Daughter		Wickham Way	y, Crof	ton, Mar	yland 211	.14
lore	ge 1 a nt of F		20a. Method of Disposition 1 ☐ Burial 2 🖁 Cremation 3 ☐ Removal from St	ate 20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Da	ate 20	c. Location - City c	r Town, State
Ħ.	urtmer artmer ortant injury		4 Donation 5 Other (Specify) 21. Signatur of Fyrheral Service Licensee	Kalas Cr		9/18/		Edgewater	, Maryland
Ba	permi Depar Impor any ir	e Jo	21. Signatur of Fyrieral Servinos Licenses		Name and Address of Fa 2973 Solomon				
			23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause or each	sed the death. Do not ente line.	, ,				Approximate Interval Between Onset and Death
	Priysician/) Medical		Immediate Cause (Final disease or condition resulting in death)	FILURE	- 10	146	SINE		Offset and Death
٠	Examiner		1 A	as a consequence of):	LED :	DEC	NEY	TIA	
		iner	Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):			10-10	, , , ,	
	cuted nd transit	Examiner	that initiated events c		_				
	icate be executed g physician and is the burial-transit	alE	resulting in death) Last Due to (or	as a consequence of):					
760	cate b physi	edical	d						
89	attending p	M/ue	IF FEMALE: 23c. If yes, outcor		Tetania			23d. Date of de	elivery
ĝ	death he atte ed for	Physician/M			Other (specify)			Month	Day Year
P.O. Box 687	at the d by the detach	Phy	Part II. Other significant conditions contributing to deat		nderlying cause given in F	Part I.	23e Did tobac	co use contribute t	o the cause of death?
ds, F	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	ted by	DEPRESS	ION			1 ☐ Yes	: /	Probably 4 🗆 Unknown
Division of Vital Records,	has be	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
æ	: The la icate ha ; page						performed	d? death?	es 2 No
lital	Physician: The this certificate ral director, pag	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Hospital:		Other	Death (Check o			Assisted
o t <	y Physer this eral di	e: To	27. Manner of Death 28a. Date of i	patient 2 ER/Outpatien injury 28b. Time of	28c. Injury at		e 5 Residenc		Living
on o	arth. rr, Afte	icat	2 Accident Investigation	Day, Year) injury	work? M 1 ☐ Yes	_		.,,	
VISI	al or Attending F s after death. I Director; After t d in by the funera	Certificate;		Injury - At home, farm, streetc. (Specify)	eet, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Ru	ural Route Number,
Ö	pital o					1		,	
	To the Hospital or A within 24 hours affer To the Funeral Dire completed filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of the control of the basis of the control of the basis of the control of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of	of examination and/or invest	tigation, in my opinion, deaf	th occurred at the	ne time, date and p	lace, and due to the	cause(s) and manner stated.
	To th withii To th comp	<	29b. Signatur and title of certifier		29c. License numb	per		Date signed (Mon	h, Day, Year)
)		30. Name and address of person who completed cause of	of death (Italy 00.) 7	D00	631	45	9/15	7/69
(HH		ARVIND DES	TA (Item 23a), (Type, P	15, DIG	ITA	CDR	LIN	THICUM
	Stat Registra		SEP 18 2009 32. Pegi	strar's Signature	and				
		-							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dorothy Mae Delauter State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day Y September 27, 2009 0005 hrs Medical Examiner Dorothy Mae DELAUTER 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 20009 Rosebank Way Washington Hagerstown 5. Social Security Number If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Director 220-16-3852 June 22,1923 Maryland M 2 X F 86 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location Yes 2 No Maryland Washington Hagerstown Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho nother traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1603 Dual Highway 21740 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Never Married 2 Married 2 X No Yes white 3 X Widowed Yes, Give Year Yes 2 X No specify: Divorced Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 quality control pipe organ parts Я 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Claude Lee Cunningham Flavia Hartle Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Spivey - granddaughter 9477 Seven Courts Drive, Baltimore, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State tober 1, Hagerstown, Maryland rtment rtant: y or oth Rest Haven Cemetery Donation 5 Other Specify: 21. Signature of Funeral Service Licen 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death aHypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical tending physician a X UNPENDED AMENDED 23a, PII, 27, permE, g897 11/6/09 TT Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 ✔ No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Completed certificate has Be this After within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

cal

	23e. Did tobacco us	e contribute to the cause of death?
	1 Yes 2 1	No 3 Probably 4 V Unknown
	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	1 ✓ Yes 2 No	1 Yes 2 No
only	one)	
a Ho	ome 5 Residenc	e 6 V Other: Scene

29d. Date signed (Month, Day, Year)

September 27, 2009

1 ✓ Yes 2	No	Inpatient 2	ER/Outpatient 3	DOA Other A Nursir	g Home 5 Residence 6 ✔ Other: Scene
27. Manner of Death 1 X Natural 5 2 Accident	Pending Investigation	(Month, Day,Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 Sulcide 6 4 Homicide	Could not be determined	28e Place of Injury - At ho	ome, farm, street, factor	y, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Cer	rtifving Physician:	: To the best of my knowledg	e, death occurred at th	e time, date and place, and	due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

26.Place of Death (Check

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

31. Date filed (Month, Day, Year) State Registra

25. Was case referred to medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month September 19,2009 **Physician** 8:24 A Jeanette Summers Divelbiss /Medical 4c. County of Death 4b. City. Town, or Location of Oeath 4a. Facility Name (If not institution, give street and number) **Examiner** Washington 14524 Finch Lane Hancock Birthplace (State or Foreign Country) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1967 | 30, 1967 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Ütáh 1 ☐ M 2 🂢 F 42 Yrs. June **Director** 217-06-2711 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Eventure. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Hancock MD Directo Washington 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 21750 14524 Finch Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1∑ No If Yes, Give Year or Dates: 11 Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Washington County College (1-4or 5+) Elementary/Secondary (0-12) Teacher Board of Education 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lynn Baker Robert L. Summers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14524 Finch Lane Hancock, MD 21750 Michael A. Divelbiss/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/25/2009 Berkeley Springs, WV Summers Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Moozka Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sus Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending if for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 2 No certificate To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Sesidence 6 ☐ Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Oescribe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, medual ARS III redere ms 11110 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar 1 - Registrar 1. Decedent's Name (First, Middle, Last)	tificate of Death	Reg. I	No. 3. Time of Death
	Physicia /Medic		HENRY JAMES EGGLESTON, SR.	and Double	SEPTEMBER	Tay 7, 2009 12:55 P M
A market	Examin		4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL CENTER	4b. City, Town, or Location of Death CLINTON		PRINCE GEORGES
	Funeral Director		5. Social Security Number 577-56-0331 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea JANUARY 31,	9. Birthplace (State or Foreign Corners) WASHINGTON, D. C.
	he Maryland 28a-f show Lift, d =1	ector	Usual Residence of Decedent 10a. State 10b. County MARYLAND PRINCE GEORGES FORT WASH 10e. Street and Number		10g.	10d. Inside City Limits 1
	th with t	al Dir	4607 PENDALL DRIVE	20744	UN	ITED STATES
2-0036	within 72 hours after death with the Maryland slene. r than "natural", or items 23a or 28a-f show tre Medical Eveniner must be traited.	by Funeral Director	1 November of Married 1 Yes 2 NO	Vas Decedent of Hispanic Origin? (SifYes, specify Cuban, Mexican, Puerto I □Yes 2☑No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
7.0.7	within 72 hc iene. • than "natu i ne Nedical	Completed	(Specify only highest grade completed) (Give life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Life. Lif	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	. Kind of Business/Industry
А	be filed wil tal Hygien d other th event, inc		17. Father's Name (First, Middle, Last)	CHER / COUNSELOR 18. Mother's Nam	ne (First, Middle, Maid	DERAL GOVERNMENT den Surname)
Jair		To Be	CHARLES ALBERT EGGLESTON		A JOHNSON	
Š	s 1 and 2 should if Health and Mei Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) ALBERT C. EGGLESTON, SR./BROTHER 4607	ng Address (Street and Number or Ru PENDALL DRIVE, F	ORT WASHIN	ty or Town, State, Zip Code) IGTON, MARYLAND 20744
Baitimore,	0		1 LaBurial 2 Cremation 3 Hemoval from State 4 Donation 5 Other (Specify)	sition (Name of natory or other place) L CEMETERY 9/26		JITLAND, MARYLAND
Dall	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee LYDIA C. THORNION JOHNSON MO0583	HORNTON FUNERAL H 439 LIVINGSTON RO	HOME, P.A. AD, INDIAN	N HEAD, MARYLAND 20640
	rificate be executed Ag physician and as the burial-transit	al Examiner	Due to (or as a consequence of):	my U U1-A. L	In fur v	Approximate Interval Between Onset and Death
	ath cel attendir or use	Physician/Medical	d	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
us, r	w requires that the de s been signed by the s should be detached f	2	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part 1.		co use contribute to the cause of death?
al Kecords,		Completed				24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
VItal	ysician: iis certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatien	Other:	ath <i>(Check only one)</i> Home 5 ☐ Residend	ce 6 □Other (Specify)
DIVISION OF	ling Ph h. After th funeral	Certification: T	27. Manner of Death Shatural Signatural Pending Injury (Month, Day, Year) 2 Accident Injury (Month, Day, Year) 2 Accident Injury At home form of the local Place of Injury At home form of the local Place of Injury At home form of the local Place of Injury At home form of the local Place of Injury At home form of the local Place of Injury At home form of the local Place of Injury At home form of the local Place of Injury At home form of the local Place of Injury At home form of the local Place of Injury At home form of the local Place of Injury (Month, Day, Year)	M 1 □Yes 2 □No	28d. Describe how	
200	al or Att s after de il Direct	Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2	Me	29b. Signature and title of certifier	29c. License number \$\int 640.55\$	290	Date signed (Month, Day, Year)
J	Q 12		30. Name and address of person who completed cause of death (Item 23a) (Type,		Atra M	W 10725
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	barker	mon, I	IN ACIDO

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Dav **Physician** 9/21/2009 SUSANNE M. ELLIOTT 4:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death CHESAPEAKE WOODS CENTER CAMBRIDGE DORCHESTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral Year) Months Days Hours Min. 1 □ M 2 🗙 F Director 213-22-8208 6/5/1927 MÄRYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Exeminer must be rediffed at Director 1 ☐ Yes 2 XNo MARYLAND DORCHESTER MADISON within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 OLD MADISON RD by Funeral 21648 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE AGENT 12 **REAL ESTATE** other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi f Health and Menta Item 27 Is marked F. LELAND MILLS Pages 1 and 2 should SUSAN DUNNOCK MILLS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GILBERT EDISON WINDSOR, III / GRANDSON 3127 STEAMER RUN, CAMBRIDGE, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Pages 1 Department of It Important: If Ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EASTERN SHORE VETERANS CEMETERY 9/26/2009 HURLOCK, MD 21. Signature of Fune 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerdiovalenta Immediate Cause (Final Arteriocelewhic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for sela consequence off or Attending Physician: The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 ☐NO 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 ☑ No certificate 2 🗔 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: A Norsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural I Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours after within 24 hours at To the Funeral Di completely filled in 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMPRIBLE MO 21613 BYRN NOMAN THANWY 503 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2009 **Physician** SEPTEMBER 3:50 PM 13 JAMES WILLARD FARLING /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Days Hours Min. 1 ☑ M 2 ☐ F Yrs April 15,1941 West Virginia 68 217-42-7501 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Martical Examiner must be multified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No Directo Frederick Maryland | Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21701 9207 Oak Tree Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 □Yes 2X No Specify. Specify. δ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Mechanic 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Charles L. Farling Genevieve Barrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10542 Liberty Road, Frederick, Maryland 21701 Teresa Boone/ Daughter Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Chapel Cemetery 9/17/2009 Libertytown, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 21. Signature Juneral Se 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) physician Physician/Medical the as attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has l or Attending Physician: The 1 ☐ Yes 2 No certificate 1 □Yes Division of Vital case reference 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1∐ Yes Inpatient Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Matural 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) Injury 5 Pending investigation n 24 hours after death.

Re Funeral Director: Af bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Hospital 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 Tohnson Hemen Shab 140 mas 31. Date filed (Month, Day egistrar's Signature State College Registrar

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'n	Physicia	20	Decedent's Name (First, Middle, Last)			:	2. Date of Death	ay Year	3. Time of Death
	/Medic		Robert C. Flake				September	11, 2009	
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9-00-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evanical Francial Francial Conference on the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the conference of the	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes : 3 □ Widowed 4 □ Divorced 1 □ Yes, Giv Year or Da	2X No e	13. Was Decedent of H If Yes, specify Cub. 1 Yes 2 XNo	dispanic Origin? (Specan, Mexican, Puerto R Specify:	cify Yes or No- lican, etc.)	14. Race - Amer Black, White, Specify: wh	
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ora	equire	ted t				-	1 🗆 Yes	2 No 3 □ Pro	obably 4 ☐ Unknown
II Kecords,	The law cate has b page 2 sh	Completed					24a. Was an autopsy performed? 1 □ Yes 2 ☑	prior to o death?	topsy findings available ompletion of cause of 2 □ No
VITA	siclan; certific	Be	25. Was case referred to medical examiner? 1 Types 2 Types (1) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Types (2) Ty		Ott	26. Place of Death			
on or	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	tion: To	27. Manner of Death 28a. Date of	npatient 2 ER/Outp of Injury h, Day, Year) 28b. Tir Inj	me of 28c. Inju	4 12 Nursing Horr	ne 5 Residence 8d. Describe how in		cify)
UIVISION	or Atten after deat Director: d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm ng, etc. (Specify)			8f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	e Hospite 24 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the ba and mann	asis of examination and	death occurred at the t /or investigation, in my	ime, date and place, a opinion, death occurre	and due to the cause ad at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Comp	Me	29b. Signature and title of certifier	18-	29c. Licens		29d. [Date signed (Month	-
			Mulder	lle M		5262	50	2p+11,	2009
	(7)		30. Name and address of person who completed cause Anurita Mendhiratta, M.		Type, Print) Research B	oulevard.	Rockville	, Marvlaı	nd
	Sta	ite	31. Date filed (Month, Day, Year) SEP 16 2009 32.	egistrar's Signature		-		, , , , , , , , , , , , , , , , , , , ,	
	Registr	ar	2FL TO 7003 1	was b.	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s				

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1208 PM Manie Fisher September 18 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X 85 Marylano Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State or items 23a or 28a-f show 1 Teles 2 □ No Injury or other traumatic event, the Medical Examiner must be notified Director Grasonville 10g. Citizen of What Country? 10e. Street and Numbe USA 16 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, Its Mcdich Exactinat once. 1 □ Never Married 2 □ Married 1 ∐Yes 2 **W**No Baltimore, Maryland 21215-0036 Black þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Someone else's home WOXK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ora ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26747 19a. Informant's Name/Relationship (Type. Print) 5trict Heights. MD Harwood James Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/26/09 Grasonville, MD. Cometery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Home, RA.
HENRY FUNERAL HOME, RA.
Sio Wash'ngton St. Cambridge, MD21613
Approximate 21. Signature of Funeral Service Licenses 23a. Part Lenter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Necrotic days **Physician** Small disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Peripheral Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed pertension attending physician and for use as the burial-tran or as a consequence of) Division of Vital Records, P.O. Box 68760, Cerebrovascular Disease heroscleratio caus Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 No 1 TYes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; ₱ 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009

State Registrar

Abhas

touad 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type,

Sinai

of Baltimore

	-	FOI	artment of Health and Mental Hygiene Stificate of Death Reg. No. 2009 3 79							
Physicia		1. Decedent's Name (First, Middle, Last) Anna Ruth Foxwell	2. Date of Death Month Day Year SEPTEMBER 18, 2009 01:00							
/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death Towson Baltimore							
Funeral Director		5. Social Security Number 222-14-5690 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthda) 85 Yrs.	Months Days Hours Min. Oct. 4, 1923 Maryland Marylan							
show	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Carroll Westmins	1 D Vos 2 X IA							
a or 28a- the netff	Direct	10e. Street and Number 3243 Sykesville Road	10f. Zip Code 10g. Citizen of What Country? 21157 USA							
Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Medical Evaminat must be motified at	by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White							
2 72	Completed by	(Specify only highest grade completed) (Giv	dent's Usual Occupation kind of work done during most of working DO NOT use retired) r/Operator 16b. Kind of Business/Industry Grocery Store							
and Mental Hygiene. is marked other than aumatic event, Ir. M.	To Be Co	17. Father's Name (First, Middle, Last) William Frank Hughes	18. Mother's Name (First, Middle, Maiden Surname) Anna E. Kragenbrink							
alth and N 27 is ma er trauma		1 1 7 7	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 280, Westminster, Maryland 21158							
Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		1 Burial 2 Cremation 3 Hemoval from State 4 Donation 5 Other (Specify)	Date 20c. Location - City or Town, State 20c. Location - City or T							
Departr Imports any Inji			2. Name and Address of Facility 11er Funeral Home, P. O. Box 207 16 Main Street, East New Market, MD 21631 ter the mode of dving, such as cardiac or respiratory arrest. Approximate							
ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit units.	dical Examiner	23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheart failure. List only ment is eon each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CARDIOGENIC SHOCK Due to (or as a consequence of): CARDIOGENIC SHOCK Due to (or as a consequence of):								
by the attending parached for use as t	Physician/Med		□ Ectopic pregnancy 23d. Date of delivery Month Day Year							
n signed by	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death							
this certificate has been sral director, page 2 should	e Completed	25. Was case referred to medical	24a. Was an autopsy findings avair prior to completion of cause death? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)							
After this uneral dir	Certification: To B	examiner? 1 Yes 2 SNo 27. Manner of Death 1 No Natural 5 Pending investigation investigation 1 Accident Phospital: 1 Snate of Injury (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) Injury (Month, Day, Year)	ent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) of 28c. Injury at Work? M 1 Yes 2 No							
Funeral Director: vitely filled in by the f		4 Homicide determined building, etc. (Specify)	City or Town, State) with occurred at the time, date and place, and due to the cause(s) and manner as stated.							
within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and title of certifier Wellow Medical Examiner: On the basis of examination and/o and manner stated.	29c. License number D41410 29d. Date signed (Month, Day, Maar) Sef 5 am le 1 8 3							
Sta Regist	ate	30. Name and a ress person who completed cause of death (Item 23a) (Typ. JOGINDER P. MEHTA, M. D. 76(2): 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature SEP 33 2009	OSLER DRIVE TOWSON, MARYLAND 21204							

28a-f show

items 23a

or other traumatic event, the Medical Examiner

n and Mental

Examiner

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** September 2158 James William 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City **Baltimore** 8. Date of Birth (Month, Day, Year)
Aug. 2, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1**X** M 2□F Days Hours 168-36-8634 63 1946 Pennsylvania Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Washington Boonsboro 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6926 Mariah Furnace Road 21713 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 966 1 96 Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify 3 Widowed 4 Divorced 968 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Special Billing Manager Communications 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William James Frey, Sr. Hibbs ည Lucy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Frey / Spouse 6926 Mariah Furnace Road Boonsboro, MD 21713 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 09/21/2009 | Frederick, Maryland 21. Signature of Funeral Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, Maryland 21713 or heart failure. List only one cause Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** aneur y sm disease or condition resulting in death) /Medical therosci Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 \sum Yes 2 \sum No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760 24 hours a

completely filled in by the funeral director, within 2

State

Registrar

29a. Certifier

(check only

29b. Signature and title of certifier

Medical

NV WY 31. Date filed (Month, Day, Year) SEF 2 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Jank

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year A M **Physician** 2009 6:44 September 11 Walter Greene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 431 Center Street 8. Date of Birth (Month, Day, Dec. 1, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Maryland 217-80-4877 Director 78 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State er than "natural", or items 23a or 28a-f show the Medical Everainer aust be notified at 1 TyYes 2 □ No Frederick Maryland Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. I filem 27 is marked other than "natural", or items 23a or 2, any holly or other traumatic event, the Medical Event any lolyry or other traumatic event, the Medical Event any lolyry or other traumatic event, the Medical Event any longe. 21701 431 Center Street United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐XNo Specify. Specify <u>Ş</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5736 Industry Lane, Frederick, MD 21701 Jennifer Maust/ Represenative 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/18/2009 Frederick, Maryland Olivet Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a donsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 1 ☐ Yes 2 🗆 No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 ☑No 1 🔲 inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manual of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation NA 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital of within 24 hours a To the Funeral D Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 16

es-

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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			State of Marylan	d / Depa	artment of l	Health a	and Mer			2009) 31	800	
			Registrar 1. Decedent's Name (First, Middle, Last)		uncate or i	2.1	Date of Deat	Reg. No. Death 3. Time of Death					
	Physicia Medic		CHRISTIAN GODWIN				SH	PT.	12^{Day}	2009	4:10	\mathbf{A} M	
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death					unty of Death			
المد	<i>!</i>		HOSPICE CENTER OF QUEEN ANNE							QUEEN ANNE'S			
	Funeral Director		5. Social Security Number 6. Sex 1 🔀 M 2 🗆 F 49	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth Month Day,	1960		nplace (State or	r Foreign	
		1	Usual Residence of Decedent						1,00				
	/land f sho	tor		y, Town or Loc	ation						10d. Inside Cit	-	
	28a-	irec		OVER							1 🔀 Yes	2 ∐ No	
	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at its event, the Medical Examiner.	Funeral Director	1300 S. FARMVIEW DR. APT. E-	1 Q	10f. Zip Code	<i>/</i> .				of What Cou			
	ath w	nue	11. Marital Status 12. Was Decedent Ever in U.S.		Vas Decedent of F		ain? (Specify)	Yes or No-		Race - Amer			
9	or its	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗶 No	If	Yes, specify Cub	an, Mexican	, Puerto Rica			Black, White	, etc.		
ဗ္ဗ	ural", ulExa	ted	3 ☐ Widowed 4 🗶 Divorced If Yes, Give Year or Dates.	1	☐ Yes 2 🗶 No	Specify:			Spe	ecify: WHI	TE		
<u>5</u>	72 hou "nat edica	Jple	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup and of work done	during most	t of working		16b. Kind	of Business I	ndustry		
7	ithin ene.	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)		O NOT use retired, PY EDITO				NEW	SPAPER	t		
2	lled w I Hygi othel	Be	17. Father's Name (First, Middle, Last)				er's Name (Fir	st, Middle, N	/laiden Surr	na <i>m</i> e)			
<u>Ian</u>	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a no 28a-f show maric event, the Medical Examiner must be notified at	입	STUART GODWIN, JR.			AGN	IES CON	WAY					
Maryland 21215-0036	sh is au		19a. Informant's Name/Relationship (Type, Print)	- T	g Address (Street						Code)		
	and 2 Health em 27 her tr		AGNES CONWAY/MOTHER	1	BIRCH RUI	N, CHE							
Baltimore,	Page 1 anent of Hant of Hant: If ite		1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 📗 🧲	ESAPEAR	sition (Name of	PION	SEPT. 2009	14		ion - City or			
	permit. Page Department of Important: If any injury or once,	13	4 Donation 5 Other (Specify) 21. Signature of Funeral School Licensee		NTER	-		_			LE, MD		
Ř	permit. Departr Import any injt	. !	1 (ARR. CX		ELECOWS ^{Add} i 30 SPEER	ROAD,	CHEST	ERTOW	AM FU N, MD	NEKAL 21620	HUME, I	P.A.	
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line	n. Do not ente	r the mode of dyli	ng, such as o	cardiac or res	piratory arre	est,		Approximate Interval Bety		
-	Physician/	61 (6	Immediate Cause (Final disease or condition	Linnald	6						Onset and D		
أمر	Medical Examiner		resulting in death) Due to (or as a consequ		7								
		er	Sequentially list conditions, b. Due to (or as a consequentially list conditions)	- Lu	y care	4							
	ed nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	ierice oi).									
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284	tificat ing ph e as th	ம	IF FEMALE:										
×	ith cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregna	al death 3 🗌	Ectopic pregnan	су			23d	. Date of deli Month		'ear	
. Box	r the a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of c 9 ☐ Unknown	eath 5 🗆	Other (specify) _					1410.111.	Juj ,		
7. O	that the	by Pr	Part II. Other significant conditions contributing to death but not res	ulting in the ur	nderlying cause g	iven in Part I	I.	23e. Did tob	oacco use o	ontribute to	the cause of de	eath?	
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Vital Records,	w required beets shown	Completed						24a. Was a		4b. Were aut	opsy findings a	vailable	
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<u> </u>	Atten r deal ctor: by the	rtifi	2			- 100 212		Location (St	reet and Nu	ımber or Run	al Route Numb	er,	
DIVISION	tal or		building, etc. (Specify)				City or Town	i, State)				
_	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending plocompleted filled in by the funeral director, page 2 should be detached for use as to completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowl (Check 2 Medical Examiner: On the basis of examination									ner stated.	
	the I	Me	only one) 3			ne time, date		d due to the	cause(s) an	d manner as s	stated.		
									/	gned (Month,			
	10		30. Name and address of person who completed cause of death (Item	23a) (Type, P		747			- '/	14/200	7		
	~ 5		J. Uheny M 2540 Centreville	Rong	Comuite	M	2161	7					
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	Registra	ir	Lenen Lenen	w pa.	14								

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 10:50 a^M September 21, 2009 JcAnne E. Gross /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 705 E. Maple Heights Ct. Rising
If Under 1 Year Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1□ M 21xF Yrs. Director 161-44-4214 4/6/1951 Pennsylvania Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 E. Maple Heights CT. 21911 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Iter 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Assistant Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Founds Ruth Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Deportment of Health and Important: If item 27 Is m any injury or other traum 705 E. Maple Heights Ct., Rising Sun MD 21911 Lisa A. Gross 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Perkasie Mennonite Cemetery 9/25/09 Perkasie, Pennsylvania 21. Signature of Funeral Service Lic 22. Name and Address of Facility Edward L. Collins Funeral Home 86 Pine Street, Oxford PA 19363 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ervical Priysician Helaslah disease or condition resulting in death) /Medical Due to (or as a consequence of): talnut **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for sels consequence Examiner The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated within 2 To the (29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Doo 33099 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 155 W. High St. Elkton, MD VRI 11M0-32. Registrar's Signature State Registrar

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		_ FOI	epartment of Health and Me Certificate of Death	ntal Hygiene Reg. No.	31802
Physicia /Medic		Decedent's Name (First, Middle, Last) ROBERT I. GOOD	2	Date of Death Month Day Year SEPT. 17, 200	
Examin Funeral Director		4a. Facility Name (If not institution, give street and number) PRINCE GEORGES GENERAL HOSPITAL 5. Social Security Number 6. Sex 112 M 2 F 71 71	Iday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	. Date of Birth 9. Bi (Month, Day, Year) C	E GEORGES Atthplace (State or Foreign ountry) IRGINIA
ier death with the Maryland Items 23s or 28s-f show resmust be notified at	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD		10g. Citizen of What C U.S fy Yes or No- can, etc.) 14. Race - Am Black, Wh Specify:	10d. Inside City Limits ty Yes 2 □ No lountry? A. erican Indian,
O Z IZ IS-0030 filed within 72 hours af Hygiene. other then "netural", or ent, the Medical Exerci-	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) MECHANIC 18. Mother's Name (i	16b. Kind of Busines	
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baltimore, permit. Pages 1 a Department of Hec Important: if item any injury or othe		1 🗆 Burial 2X Cremation 3 🗆 Hemoval from State	ERS CREMATORY 9-22-2 22. Name and Address of Facility CHAMBERS FUNERAL HON 5801 CLEVELAND AVE.	ME & CREMATORIUM	,P.A.
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To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	death occurred at the time, date and place, an Vor investigation, in my opinion, death occurred 29c. License number	id due to the cause(s) and manner if at the time, date and place, and did 29d. Date, signed (Mo.	ue to the cause(s)
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Type, Print) 001 HOSPITAL DR., CHEV	VERLY, MD. 20785	-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Dorothy Margaret Galvin 12:10 p M September 14, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Collingswood Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 93 061-07-1239 Aug. 29, 1916 New York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Show 10a. State r 28a-f show notified at 1 X Yes 2 No Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or dical Examiner must be r 299 Hurley Avenue 20850 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 21X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the find the Edward Heggarty <u>Carolyn</u> Dixon Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trau James F. Galvin/Son Barrington Fare; Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation Ft. Lincoln Crematory 9/21/09 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Ent-r the dise x e, shock, or heart failur 1. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest tonly one cause on each line. Immediate Cau (Final Physician disease or condition resulting in death) Medical consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 1 ☐ Yes 2 No 9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) 9□Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed Anemica 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an has autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide mpletely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

EISAYYAID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Item 23a) (Type, Print) / Collar Dr. Rockville, MO 20850 82. Registrar's Signature

Baltimore, Maryland 21215-0036

Box 68760,

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Division or Vital Records,

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ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a. State other traumatic event, the Medical Exaction rust be notified at Washington 1 ☐ Yes 2 No **Funeral Director** Knoxville <u>Maryland</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21758 United States 18114 Morgan Pine Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 ☐ No 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1951-54 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lauretta Elizabeth Castle ပ္ Newton Clay Himes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 Is any Injury or other trau 18114 Morgan Pine Road, Knoxville, Maryland 21758 Evelyn L. Himes / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Brownsville Church Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Brownsville, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC CANCER OF Unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeati director, page 2 should be detached for use as the burial-transit in by the funeati director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ UROPATITY OBSTRUC true 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No COLON CANCE 24a. Was an autopsy performed 0 W RIAMOMA 1 ☐ Yes 2 ☐ No History 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No a 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide To the Hospital of Within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. 0 D40307 asu JPS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opossumtown Pike, Frederick, Maryland 21701 Eugene Casagrande MD 1564 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 16 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3 Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) - Month Year Physician 1125 AM 11,2009 MK /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** HOWK If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1 XM 2 □ F 76 Yrs 214-28-8223 9/11/1933 MD Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD KENT ROCK HALL 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA 5228 SKINNERS NECK RD. 21620 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1960 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE ş 3 XWidowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SEAFOOD WATERMAN N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental F Important: If Item 27 Is marked ot any injury or other traumatic even once. CATHERINE REIHL HERMAN HEINEFIELD, SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOSEPH F. HEINEFIELD/SON 5080 SKINNERS NECK RD. ROCK HALL, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL 9/15/09 ROCK HALL, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 21. Signature of Funeral Service License Du Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List or con Immediate Cause (Final disease or condition resulting in death) **Physician** vy oco /Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the pest 12 months? 1 □Yes 2 □ No 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 □ Yes 1 ☐ Yes s after deam. ral Director. After this control of the funeral director, particular to be a feet of the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 150 A) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division of Vital Records, within 24 hours a Hospital

> 12 State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature

(Check only one)

Medical

npleted cause of death (Item 23a) (Type, Print)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** EVELYN SOUARES HOPKINS SEPT. 2009 2055 8. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WORCHESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 3/21/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 □ M 2 🕅 F 83 Director 215-20-0792 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglens. Internal, yor items 23a or 28a-f show Important: If the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Exeminant be retified at 1 ☐ Yes 2 No Director MD KENT KENNEDYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28082 LAMBSMEADOW RD. USA 21645 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Completed by Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER-OPERATOR HOSPITALITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE SOUARES MAUDE WIGGINS ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE B. HOPKINS/SON 28410 LAMBSMEADOW RD. KENNEDYVILLE, MD 21645 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CRUMPTON CEMETERY 9/14/09 CRUMPTON, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 370 W. CYPRESS ST. MILLINGTON, MD 21651 ellous 2 a. Part 1. Eyrs the dise of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertension and /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to finding dide cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Ye ar 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2 **X**No Vita 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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To the Funeral I

completely filled

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29b. Signature and title of certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

0064120

9/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9733 31. Date filed (Month, Day Yea Zeechan Aad

32. Register's Signature

Health way Drive Berlin MD 21811.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 19 2009 Marjorie Mae Harper 4:00a. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 7, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Months Days Hours 218-16-9032 86 1923 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge 1 XYes 2 □ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 520 Glenburn Avenue 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ₩ Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) line worker 8 seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hamilton Manning Eva McCollister 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nellie Foxwell daughter 603 Radiance Dr., Cambridge, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 9/22/09 East New Market, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee lune 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) 4cas arkinson Due to (or as a consequence of): sphagia Due o (o) as a consequence of) Sequentially list conditions, if any his ling light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1' Natural

Examiner burial-trar Box 68760, attending physician The law requires that the death certificate be for use P.0. the detached þ has page 2 certificate this

Examine Physician/Medical \$ Completed Be 2 Certification: After

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be redified at

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other the any injury or other traumatic event, Its once.

Physician

/Medical

3altimore, Maryland 21215-0036

within 72

Director

Funeral

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Completed

Be

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Division of Vital Records, Hospital or Attending Physician: n 24 hours after death, te Funeral Director: Af npletely the

within To the ပ္

Medical

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Mpnth, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

1 ☐ Yes 2 ☐ No

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State Registrar

	1-	For Stata Registrar		•	ent of Health and ate of Death	R	eg. No. 2009	3 8 0 3
Physician (Madian)	1.	Decedent's Name (First, Middle, La	st) Joanne Jac	kson		2. Date of Deat Month Septembe	Day Year	
/Medical Examiner	4a.	Facility Name (If not institution, giv			ty, Town, or Location of De		4c. County of Dea	
Funeral Director	5.	Clade Valley Nursessocial Security Number 6. Security Number 6. Security Number 127-34-1944		. /ast birthday) If Unc Yrs. Month	Walkers der 1 Year If Under 24 H s Days Hours M	rs. 8. Date of Birth	Year) 9. Bi	erick hthplace (State or Foreign ounity) orth Carolina
natural; or items 23a or 28a-f show iteal Examinar must be notified at sted by Funeral Director	-	a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
28a-f s cuiffied ector	10	est Va. Jeffer	son Ke	arneysvill	e		0g. Citizen of What C	1 ☐ Yes 2X No
item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	١.	3 Windmill Lane Marital Status □ Never Married 2□ Married 3 ₩ Widowed 4 □ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	J.S. 13. Was Dec	25430 Sedent of Hispanic Origin? Secry Cuban, Mexican, Pu 2⊠ No Specify:		United 14. Race - Am Black, Wh	States erican Indian,
vent, the Medical Se Completed		15. Decedent's Education (Specify only highest gradule) Elementary/Secondary (0-12)	de completed)	16a. Decedent's Us (Give kind of v life. DO NOT	work done during most of v	working	16b. Kind of Business	
event, the Be Com	17	Father's Name (First, Middle, Last,	College (1-4or 5+) 2	Real E	state Agent 18. Mother's N	lame (First, Middle, I	Real Est Maiden Sumame)	ate
To To		irgil Morrow Sr.	Type Print)	19h Mailing Addre	Essie Street and Number or	Whitehead	City or Town State	Zin Code)
ry or other traumatic eve	20.	honda Jackson / a. Method of Disposition 1	Daughter 20b.	23 Windm: Place of Disposition (A cemetery, crematory o	ill Lane, Ke	arneysvill Date	le West VA 20c. Location - City o	25430 r Town, State
any injury or	_	. Signature of Funeral Service Licer	1111	22. Name Stauf	and Address of Facility fer Funeral 1 Opossumtown	Homes P. A	Arlington. A. Herick, Ma	
sician edical miner	Im di re	Ba. Part1. Enter the disease, or com shock, or heart failure. List only imediate Cause (Final sease or condition sulting in death)	a. Due to (or as a consection)	ia quence gittial	ode of dying, such as card		est,	Approximate Interval Between Onset and Death MENITH MONTHS
the burial-transit	Ca tha re	inguentially list conditions, any, leading to infinediate use. Enter Underlying uses (Disease or injury at initiated events sulting in death) Last	c. Due to (or as a consec					
ıse as 1/Me	IF 23	FEMALE: b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of de Month	Blivery Day Year
p p	· Fa	rt II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying	g cause given in Part I.		bacco use contribute t es 2 □ No 3 □ F	
r, page 2 should						24a. Was a autops perforr 1 □ Yes 2	sy prior to	
nis certificate Il director, pag To Be Col		. Was case referred to medical examiner? 1 ☐ Yes 2 ※No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ I	0.1	eath (Check only on	e)ence 6 □Other (Sp	ecifu)
Atter t funera funera	27	Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No		ow injury occurred	July
To the Funeral Director: After the Completely filled in by the funeral Medical Certification;		3 Suicide 6 Could not b determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factify)	ory, office	28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
To the Funeral Director: completely filled in by the Medical Certifical	29	a. Certifier (Check conty one) 2 Medical Example one)	ysician: To the best of my kn niner: On the basis of examinated and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and pla on, in my opinion, death oc	ice, and due to the ca courred at the time, do	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
= = =	29	b. Signature and tille of certifier			POOBILITY POE		9d. Date signed (Mon	
2 00		VIEV			112 4 / 4 7 A T			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene' 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Day **Physician** JACKIE M. JONES 2009 7:21 P₩ 19 Sept /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Talbot The Pines Easton Genesis HealthCare If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 1 DXM 2 □ F Months Days Hours Min Yrs. 220-26-8591 Director 8/31/1930 MÄRYLAND Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location Director 1 Yes 2 No MARYLAND **TALBOT EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 PARK LANE 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 Never Married 2 X Married ŏ 1 ☐ Yes 2 XNo Specify: þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **SALESPERSON AUTOMOBILE** 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RALPH H. JONES 2 **EVELYN ROE** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 JEAN F. JONES / WIFE 72 PARK LANE, EASTON, MD 21601 Department of Heam Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State injury or 1 ☐ Burial 2 XCremation 3 ☐ Removal from State MID SHORE CREMATION CENTER 9/21/2009 CAMBRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) Artre Funeral Service Licenses 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 Enter the disease, or contain caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician month /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? significent conditions contributing to death but not resulting in the underlying cause given in Part i. ۵ rience 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was en autopsy this certificate 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check onl one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Dursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crowler 610 31. Date filed (Month, Day, istrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Jones

Jackie

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** William Charles Jones September 17 2009 8:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 411 Robbins Street Cambridge Dorchester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct | 1979 | 1961 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 47 Maryland Director 214-80-6973 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Dorchester sa or 28a-f sh t be notifled Cambridge 1X Yes 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 411 Robbins Street 21613 USA ral", or items 23a Examiner must b Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatte event, the Medical Examines 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) heavy equipment operator construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Donald Jones Hilda Travers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Viether Soto wife 411 Robbins St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 9/21/09 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 30 mm /Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 111551VE burial-trar physician Physician/Medical the as IF FEMALE: for use a If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No _____ page 2 autopsy performe certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide

law requires that the death certificate be executed Box 68760, P.0. or Vital Records,

Maryland 21215-0036

Baltimore,

Physician: or Attending after death. filled in by the To the Hospital o within 24 hours aff To the Funeral D completely

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year,

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 CATLYN NORMA RAE JONES SEP 15 6:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Director Maryland 24 Sept. 15, 2009 None Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f shorthe Wedical Examiner must be notified at Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7208 West Huff Blvd death 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc filed within 72 hours after 1 Never Married 2 ☐ Married 21215-0036 1 ☐Yes 2 No <u>≽</u> Specify. Specify: Bi-racial 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than College (1-4or 5+) None None Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. 2 Daniel Brian Jones Christine Chavez Torres 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Jones/Mother 7208 West Huff Blvd; Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 9/22/09 Brentwood, Maryland 21. Signature of flungral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville PIke; Rockville, MD 20852 23a. Part 1. Ent/ the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or art failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caute (Final disease or condition resulting in death) **Physician** EXTREME PREMATURITY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of): physician the burial Box 68760 pe Physician/Medical as attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) detached o the 9 Unknown ď. signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ be 1 ☐ Yes 2 🔯 No 3 🗍 Probably 4 🗌 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s autopsy certificate of Vital 1 ☐ Yes 2 🔽 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospitan C. within 24 hours after death.

To the Funeral Director: After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of pertified 29c. License number 29d. Date signed (Month, Day, Year) 0101236989 (VA) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 SHANNON LAMB LCDR MC USN 31. Date filed (Month, Day, 22. Registrar's Signature State park Registrar

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Certificate of	Death	Reg. N	10. 0119	3 8 2
	DI .		1. Decedent's Name (First, Middle, Last,)				2. Date of Death		3. Time of Death
	Physici /Medi		Charles	Thomas	Joho:	lske		September		3:27 P.M
A. S.	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	4	c. County of Death	
- April			Shady Grove Adven			Rockv			Montgomer	
	Funeral		5. Social Security Number 6. Set	x 7. Age (☑M 2□F	(In yrs. last birt	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		66			Sept. 1/,	1943 Wash	ington, DC
	yland yland		10a. State 10b. County	1	0c. City, Town	or Location			-	10d. Inside City Limits
	a-f sh	ģ	Maryland Montgome:	rv	Gai	thersburg				1⊠Yes 2∏No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Cour	ntry?
	23a (23a ust b		202 Twelve Oaks D	rive		2087	8	1	United St	ates
	tems	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto		14. Race - Americ	can Indian,
36	within 72 hours after death with the Maryland liene. than "natural", or items 23a or 28a-f show be Mcdical Eventions, ust be putfled at	by F	1 ☐ Never Married 2x Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 🛣 No If Yes, Give		1 □Yes 2X No		,	Specify:	
Maryland 21215-0036	hour tural	ed t	15. Decedent's Edu	Year or Dates:	162	Decedent's Usual Occu	unation	16h	Wh	ite
15	in 72 n "na n "na	Completed	(Specify only highest grade	le completed)	10a.	Give kind of work done life. DO NOT use retire	apation a during most of work ad)	sing 160.	Kind of Business/In	dustry
212	d withir giene. r than	EO	Elementary/Secondary (0-12)	College (1-4or 5+)					ational A	rchives II
b	be filed with tall Hygiene de other the event, the	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Maide		
/lai	should be nd Menta marked imatic ev	To E	Charles J	ames Joho	lske			Marv Nei	1 Watkin	ıs
lar)	sho and is me		19a. Informant's Name/Relationship (Ty	pe. Print)	19b.	Mailing Address (Stree	t and Number or Ru	ral Route Number, City	y or Town, State, Zij	Code)
≥,	and and n 27		Ruth A. Joholske/W			2 Twelve Oa		Gaithersb	urg, Mary	land 20878
ore	ges 1 t of H if iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	Removal from State	20b. Place of cemetery	Disposition (Name of crematory or other pla	ace)	Date 20c.	Location - City or To	own, State
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic en once.		4 □ Donation 5 □ Other (Specify)	ternoval from State	Ft. Lin	ncoln Cemet	ery 9/24	/2009 Bre	ntwood, M	Maryland
3ali	permit Depar Impor any in		21. Signature of Funeral Service License		10	22. Name and Addr	ess of Facility De	Vol Funera	1 Home	
			Mechan	Mu	we			r., Gaithe	rsburg, M	
			 23a. Part 1. Enter the disease, or complishock, or heart failure. List only or 	cations that caused the ne cause on each line.	e death. Do n	ot enter the mode of dy	ring, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
The same	Physician		Immediate Cause (Final disease or condition resulting in death)	Sepsis						Onset and Death
mark!	/Medical Examiner			Due to (or as a c		,				
b.		r.	if any leading to immediate	Non Hodgk Due to (or as a c						
)	uted J insit	min	Cause (Disease or injury	2 40 10 (01 40 4 5	onocquonoc o	,.				
,	exec in and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of	·):				
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68	ertificate be executed ling physician and e as the burial-transit	Medical					- 1000			
~	S		200. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [3 ☐ Ectopic pregnan	ICV		23d. Date of deliv	ery
О.	Physician: The law requires that the death this certificate has been signed by the atterral director, page 2 should be detached for u	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at tir		5 ☐ Other (specify)			Month	Day Year
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Š,	res the signe be d	by	Part II. Other significant conditions cor Renal Failure	itributing to death but r	not resulting in	the underlying cause gi	ven in Part I.		o use contribute to the	
0.0	w requir been s should	eted	Kenar Farrure					1 Li Yes	2 NO 3 Prof	oably 4⊠ Unknown
ec Sec	e law has l	Completed						24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
a	ician: The I certificate ha ector, page 3							performed? 1 □ Yes 2 🕱		2 🗆 No
Division of Vital Records,	ding Physician: h. After this certific funeral director,	Be	25. Was case referred to medical examiner?	lospital:		Ot	h	h (Check only one)		
o	Phys r this ral dii	Ë.	1 ☐ Yes 2X No	1 🔀 Inpatient 28a. Date of Injury	2 ER/Out	Datielli 3 DCA	4 Li Nursing Ho	ome 5 Residence 28d. Describe how inj		(y)
o	Attending I r death. ector: After by the funer	ţi	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Y	<i>(ear)</i> In	ury Wo	rk? ☐Yes 2 ☐ No	20d. Describe flow inj	ary occurred	
/isi	or Attendation of Attendation of Director:	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farr	n, street, factory, office		28f. Location (Street a	and Number or Run	al Route Number
ă	alor A s after I Direct	Certification: To	4 ☐ Homicide determined	building, etc. ((Specify)			City or Town, Sta	ite)	,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by		29a. Certifier (Check only) 1X Certifying Phys 2 Medical Examin	sician: To the best of r	my knowledge,	death occurred at the t	time, date and place	and due to the cause	(s) and manner as	stated.
:	To the Hos within 24 h To the Fun completely	Medical	one)	ner: On the basis of ex and manner stated	d.	or investigation, in my	opinion, death occui	red at the time, date a	nd place, and due to	o the cause(s)
_ 1	Verith voith com	Σ	29b. Signature and title of certifier			29c. Licen	se number	29d. D	Date signed (Month,	Day, Year)
	17/		Mamai Hi	20 m		D	62562	Sep	tember 18	, 2009
	10		30. Name and address of person who co	mpleted cause of deat	th (Item 23a) (1	ype, Print)				
			Madhavi Hubbly, M.			Center Dri	ve, Rockv	ille, Mary	1and 2085	0
	Sta Registr	_	31. Date filed (Month, Day, Year)	32 Registrar's	signature	bulled				
	negistr	at .	SEP 22 2009	1 Keneur	19.19	Men				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	iai yianu	•	rtificate of				Reg. No.	7.1111	9 :	, 1813
	Dharini		1. Decedent's Name (First, Middle,	Last)		-			2	Date of Dea	th Day	v. o Yea		Time of Death
	Physici /Medi		PAUI	Е	JOHNSC	N			5	eftem De	17	7 200	9	2:30 PM
	Examir	ner	4a. Facility Name (If not institution,				4b. City, Town, o		of Death	•		County of D		
			DOCTORS COMMI 5. Social Security Number		TAL ge <i>(In yr</i> s. <i>la</i> :	et hirthday)	LANI If Under 1 Year		er 24 Hrs. 8	. Date of Birth		RINCE		GES (State or Foreign
	Funeral Director		212-68-5469 Usual Residence of Decedent	1 X M 2□ F	50	Yrs.	Months Days	Hours	Min.	(Month, Day NOV . 5,	, Year)		Country) ENNE	
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. I	nside City Limits
	Mary a-f sh	ţċ	MD. PRINCE	GEORGES			BOWIE							Yas 2 □ No
	or 28	ire	10e. Street and Number				10f. Zip Code			1	10g. Cit	tizen of What	Country?	
	23a (Funeral Director	13307 10tl	ST.			20	715				U.S.	Α	
	tems tems	nue	11. Marital Status	12. Was Decedent Armed Forces	7	13.	Was Decedent of H If Yes, specify Cuba	lispanic C an, Mexica	Origin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)		14. Race - A Black, W		ndian,
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a findled Examinating to justified at once.	<u>چ</u>	1 ☐ Never Married 2 ☐XMarrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ∐Yes 2 [7] If Yes, Give Year or Dates:	No		1⊡Yes 2√∑No	Specif	y:				HITE	
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0	filed withi I Hygiene. other than ent, trees	Be C	17. Father's Name (First, Middle, L	ast)			I LOTIDE		her's Name (First, Middle,	Maiden		IDING	
lan	ild be denta rked ric ev	To B	VICTOR	JOHN:	SON				I	RUTH	C	ARTER		
Maryland	2 should be fil and Mental H Is marked ott aumatic ever	-	19a. Informant's Name/Relationshi	(Type. Print)		19b. Maili	ng Address (Street	and Num	ber or Rural	Route Numbe	r, City c	or Town, Stat	e, Zip Cod	de)
	1 and 2 Health em 27 I	L 13	NANCY JOHNSON	/WIFE		1330			BOWIE		207			
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation :	☐ Removal from State	20b. Pla	ace of Dispo metery, crea	osition (Name of matory or other plac	ce)	Dat	e	20c. Lo	ocation - City	or Town,	State
Baltimore,	t. Pag tmen tant:		4 ☐ Donation 5 ☐ Other (Sp.	ecify)		- · · - · · · · · · · · ·	CREMATO		9-22-2		_	IVERDA		
Bal	permit. Page Department (Important: If any injury or		21. Signature of Funeral Service L	eënsee UUUUUU	Z M00	091 5	2. Name and Addre HAMBERS 1 801 CLEVI	ss of Faci FUNER ELAND	KAL HON AVE.	IE & CE	REMA RDAL	TORIUM E. MD.	1,P.A 207	37
No. of the last	Physician		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that cause only one cause on each l	d the death.	Do not en	ter the mode of dying the fact Co	ng, such a	as cardiac or	respiratory arı	rest,	5, 7	App	proximate erval Between set and Death
-	/Medical Examiner		resulting in dealin)	Due to (or as	s a conseque	ence of):	6 1							
		e e	Sequentially list conditions,	b. Due to for as	e a conseque	rice cly:	fac	ur c						
	uted d ansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,			cer							
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	ertifica ling pl e as tl		IF FEMALE:								-1		-	-
O. Box	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown	2 Fetal o	death 3[☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	:у				23d. Date of Month	delivery Day	/ Year
о. С.	that ned b deta		Part II. Other significant condition	s contributing to death I	but not result	ting in the u	nderlying cause giv	en in Part	tł.	23e. Did to	bacco	use contribut	e to the ca	ause of death?
rds	quires en sign uld be	ed by								1 □ Y	es 2	□ No 3□	Probably	4 Unknown
Records,	e law requir has been s e 2 should	Completed								24a. Was a		24b. Were	autopsy	findings available
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'n	ding Ph After th funeral	jon	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, D.	ury ay, Year)	28b. Time o Injury	Wor			d. Describe h	ow inju	ry occurred		
isic	death death stor: / the 1	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 280 Place of In	iun - At hom	ne form st	M 1 □ reet, factory, office	Yes 2	-	f. Location (S	troot at	nd Number o	r Dural Do	oute Number
Division	lor A after Direct	Certification:	4 Homicide determin	ed building, e	tc. (Specify)	ie, iaim, su	eet, lactory, office		20	City or Tow			nurarrio	ate rainber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificy completely illied in by the funeral director,	Medical C	29a, Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best caminer: On the basis and manner s	of examination	ledge, deat on and/or ir	th occurred at the tinvestigation, in my o	me, date opinion, d	and place, ar eath occurred	nd due to the o	cause(s	s) and manne d place, and	r as state due to the	d. cause(s)
		Me	29b. Signature and title of certifier	_			29c. Licens	e number	r	-	_	ate signed (M	-	Year)
	5		+ fasi1.	Alemu			165	909			7	1201	99	
			30. Name and address of person w		death (Item	23a) (Type,	Print) LUCK Ro	ad	Lanh	um ./	n0.	201	06	
	Sta		31. Date filed (Month, Day, Year)		rar's Signatu	re	4.0	J						
	Registr	ar	SEP 22 21	109 Dentin) B.	gran	-							

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 2009 Virginia May Lackey 716pm Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Mandrin Hospice House Harwood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 77 A . Age (In vrs. last birthday **Funeral** Hours VA 187254 1925 84 218-34-5365 **Director** Usual Residence of Decedent f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sl raumatic event, the Medical Examiner must be notified i 1 Yes 2XXNo Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20764 USA 4958 Chestnut Street Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes No Specify: Specify: Completed 3XXWidowed 4 □ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 10 Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Byers Ashton Owen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1880\ East\ 135\ Ave.\ Thorton,\ CO.\ 80241$ Daniel Lackey III/Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot XX Burial 2 Cremation 3 Removal from State 9/19/2009 4 ☐ Donation 5 ☐ Other (Specify) Woodfield Cemetery Galesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Die to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes ∠ Ma 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State

Registrar

DHMH 17 Rev 7/2009

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EIN

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amerstate of Maryland / Department of Health and Mental Hygiene: 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 14,2009 4:00 Ам Alma M. Lynch 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 2600 Ross Road Chevy Chase | Months | Days | Hours | Min. | Reb. 12, 19 Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Months 1 □ M 2 🖾 F Illinois 77 1932 327-26-5907 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 12 Yes 2 No MD Chevy Chase Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20815 2600 Ross Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Native American 1 ☐ Yes 21 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Private Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earlean Jones Leon Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 Ross Road, Chevy Chase, Maryland 20815 Clifton Terry/Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☑ Removal from State Queen of Heaven Cem. 09/22/2009 Gilbert, Arizona
22. Name and Address of Facility McGuire Funeral Service, Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liq 7400 Georgia Avenue, NW Washington DC 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 15 Months Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1

Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 TNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certific

Division of Vital Records, P.O. Box 68760,

cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar certificate Hospital or Attending Physician; filled in by the funeral director, 24 hours after death. Funeral Director: After completely To the within 2 To the 1 3

Physician

/Medical

Examiner

Director

Funeral

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Completed

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machael Examiling mast be neutified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, "Year") 22 SEP



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ralph V. Boccia, M.D., F.A.C.P.

D29675

September 17,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 45 A M POOR OF redmoters 9 June Elizabeth Linton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner tahrney Keedy Home
5. Social Security Number 6. Sex 7. Age Boons boro nder 1 Year If Under 24 Hrs. 9. Birthpidce (State or Foreign Country)
Maryland ٤ 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/13/1922 **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 220-16-1298 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic event, the Mexical Expression or other traumatic events and the Mexical Expression or other traumatic events and the Mexical Expression or other traumatic events and the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the Expression of the E 1 ☐Yes 2 ☐ No Director MD Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21713 United States 8507 Mapleville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify. Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 animal caretaker Microbiological Assoc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Keilholtz Ethel Bell John ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13409 Rabbit Run Terrace, Union Bridge, MD 21791 Glenda Etzler/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Faith UCC Cemetery 10/1/09 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home 106 E. Church St., Frederick, MD 21701 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tue (1) or es a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examine law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant et time of death 23b. Wes decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has bage 2 s autopsy 2 🗷 No Vital 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 🗖 🛱 o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Aatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier frecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State Registrar

Elizabeth Linton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Mortif, Day, Year)

Dr. Khalid Waseem / 1126 Opal Court, Hagerstown, MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ pretta Love Myerly M 0028 09 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington Cty
5. Social Security Number HOSPITA 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) Country)

St Virginia (Month, Day, Year) 01-22-1930 1 D M 2 P Hours Min. Director 218247738 West Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director Hagers town 1 Yes 2 No MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 741 Anhetam Drive 21742 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White is marked other than "natural", 3 Widowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file ဂ Leonard Lewis Kane Fannie V. Orr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 15230 Clear Spring Rd. Williamsport Maryland 21795 Beverly A. Hensley Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 9/30/2009 Hagerstown Maryland 21. Signarure of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ a. Complications DE MULTICE EMBOLT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ATREAL FIRRILLATION ISCHEMIC CARDING DISEASE WITH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ITCHEMIC REZIGHERIAL VACCULAR DISCASE Exami Cause (Disease or iinjury that initiated events SEVELE SURGERY FOR physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Dicheter Mellibs 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide death. Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my calains death account at the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29c. License number 29d. Date signed (Month, Day, Year) Kara 038764 9/27/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 RE STE 127 0. RIGULTAD MV Illio medical

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			Registrar 1. Decedent's Name (First, Middle,	Last)		or invocato or		2. Date of Deat	h		3. Time of Death
	Physicia		Joseph Douglas					Month September	er 12,	2009	5:20 PM
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Death			ty of Death	<u> </u>
	Examin	eı	Buckingham's Ch		ed Living	Adamsto	own		Fr	ederio	ek .
	Funeral			6. Sex 7. Ag	e (In yrs. last birthd		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign try)
	Director		215-38-7627	1 ⊠ KM 2□ F	89 Yrs	S. Months Days	Houis Will.	May 1,	1920		land
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Lacation				1	0d. Inside City Limits
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	eath	era	7034 Upland Rid	12. Was Decedent	Ever in U.S.	13. Was Decedent of If Yes, specify Cub		pecify Yes or No-		ace - Americ	
0	fter d r iten iner	Fu	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	No			o Rican, etc.)		ack, White,	
20	urs a	by	3 ☑ Widowed 4 ☐ Divorced	ed 1 Maryes 2 □ If Yes, Give Year or Dates:	1941-	1 ⊡Yes 2 🛣 No	Specify:		Spec	eify: Wh	ite
9500-61212	72 ho natur	Completed by Funeral Director	15. Decedent's (Specify only highest	s Education	16a. De	ecedent's Usual Occu	pation during most of work		16b. Kind of	Business/Ind	dustry
7	thin 3e.	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+) lis	fe. DO NOT use retire	ed)		1	G	Δ
7	ed wi	ပိ		5+	Mil	itary Off:	T	ne (First, Middle, I			es Army
ב	be fill tal H d ott	Be	17. Father's Name (First, Middle, L George Washingt					ne Diggs	vialueri Surri	ziiie)	
$\frac{2}{5}$	ould d Mer narke	မ				lailing Address (Stree			r City or Tay	ın Stata 7ir	Cadal 20852
Maryland	d 2 sh th an 7 is r traur		19a. Informant's Name/Relationsh Douglas Mitchel		104	01 Strath	nore Park	Ct. #20	3, N.	Bethe	isa, MD
a O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be usefilled at once.		20a. Method of Disposition		20b. Place of D	isposition (Name of			20c. Location	n - City or To	wn, State
aitimore,	ages ent of t: If if		1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (Sp			crematory or other pla en Cremato		. 15, 2009	rederi	ick, M	aryland
	nit. F artme ortan injur E.	li	21. Signature of Funeral Service L			22. Name and Addr Resthaven		1009			
ñ	Dep Imp any any					9501 Cato	runerar ctin Mtn.	Hwy. Fr	, skko ederic	k. MD	21701
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1000	/Medical		resulting in death)	a	a consequence of)	:					
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ROX	death of	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			1	Month	Day Year
o.	w requires that the death certifi been signed by the attending should be detached for use as	Physician/M	1 □Yes 2 □No 9 □ Unknown	9 □ Unknown	ar into or dodn	one (speedy)					
J.	requires that the been signed by th hould be detache		Part II. Other significant condition	ns contributing to death t	out not resulting in th	ne underlying cause g	iven in Part I.	23e. Did to	bacco use co	ontribute to t	he cause of death?
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S	law rec las bee 2 shou	lete						24a. Was a		b. Were auto	opsy findings available
	The la ate has bage 2	Completed by				-		autop	med?	prior to co death? 1 ☐ Yes	ompletion of cause of
Vital		a)	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or	2 K No	TI_Tes	2 🗀 140
	Physician; this certific ral director,	O	examiner? 1 ☐ Yes 2 🖾 No	Hospital: 1 ☐ Inpat	ient 2 ER/Outp	atient 3 DOA	thor:	lome 5 ☐ Resid		Other (Speci	ify)
Division of		Certification: T	27. Manner of Death	28a. Date of Inj (Month, D	ury 28b. Tin ay, Year) Inju	ne of 28c. Inj	ury at ork?	28d. Describe h	ow injury occ	curred	
Ö	Attending I r death. ector: After by the funer	atio	1 Accident 5 Pending investig	ation	ay, 10a/		∐Yes 2 □No				
N N	i or Attend after death Director: d in by the f	tific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of in	jury - At home, farm tc. <i>(Specify)</i>	, street, factory, office		28f. Location (S City or Tow	Street and Nu n, State)	mber or Rur	al Route Number,
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	within 2 To the I	Jed	one) 29b. Signature and title of certifier	and manner s	tated.	29c Lices	nse number		29d. Date sig	ned /Month	Dav Year)
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	FYSTER		30. Name and addres of person verte Wayren,				sville N	m 21773			
	Sta	te.	31. Date filed (Month, Day, Year)	32. Redist	trar's Signature		DVIIIC9 I	W 21113			
	Registr		SEP 16	3 2009 Den	war p.	parker					
DIII	10147 0 40	0001				1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Jak Fosus All Copies Are Legible.

Amend I tem 24a per physics Fosus All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 13 2009 3:41a September Anna Mae Miller 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick 7212 Rainbow Lane Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 □ M 2 🔀 F Months Days Hours 76 May 16, 1933 Maryland 220-26-5888 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 1 No Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7212 Rainbow Lane 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Frederick Board of Ed. Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Burkett Oscar Fisher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2902 Marker Road, Middletown, Maryland 21769 Scott Miller/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery 9/16/2009 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Fundral Service Lice Stauffer Funeral Homes P. A. Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): wesh disease or condition resulting in death) CULE Sequentially list conditions, if any mading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown dysp(7517) 24b. Were autopsy findings available prior to completion of cause of death? nhomo autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation

Box 68760,

sertificate be executed

DIVISION OF VIIAL DECONDS, F.O. DOX 00/00,
ital or Attending Physician: The law requires that the death certificate be execut as after death.
ral Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-tran
Certification: To Be Completed by Physician/Medical Exan

Physician

/Medical

Examiner

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Mental Exemine must he restrict once.

Physician

/Medical **Examiner**

Baltimore, Maryland 21215-0036

To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by

Tuden

State Registrar

DHMH 17 Rev 1/2001

(2) Year) 16 31. Date filed (Month, Day,

29b, Signature and title of certifier

6 ☐ Could not be

<-- Natural

2 Accident

3 🗌 Suicide

29a, Certifier

4 Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0366 32 Registrar's Signatur

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and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

50 parke

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 11:30 P M 2009 Stephen Devane Moran September 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 1471 Key Parkway, Apt. C-4 Frederick Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1**⊠** M 2□ F Months Hours Yrs. Director 219-54-8591 58 6, 1951 Maryland Sept. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I're Medical Evaminer must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1471 Key Parkway, Apt. C-4 21702 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Vice President Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Osborn Devane Moran Eleanore Susan Montgomery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1471 Key Parkway, Apt. C-4 Frederick, Maryland 21702 Eleanore S. Moran / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 14, 2009 4 Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner 11 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 11 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 🗆 Yes 2 🗷 No Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1□Yes 2□No NA 051 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar 30. Name and address of person who

21215-0036

Maryland

Baltimore.

P.O.

Division of Vital Records,

town Pike

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month September 17,2009 **Physician** 9:10P Lee Robert Martin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 17, 1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 √ M 2 □ F Maryland 87 219-12-2874 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Charles La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 USA 8100 Applegrove Court by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 is marked other than any Injury or other trainmant. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman H. Martin Ada Clements 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Wheatley/Daughter 8100 Applegrove Ct. La Plata,MD 20646 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Sacred Heart Cemetery 9/23/2009 La Plata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 AREHART ECHOL'S FUNERAL HOME, P.A. M00945 211 St. Mary's Ave. La Plata, MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CARDIAC ARRHYTHMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed CANCE as the burial-transi PROSTATE and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a detached for 1 □Yes 2 □No 9 Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STEOPOROSIC Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? page 2 After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Universing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, of Vital Records, Division

Registrar

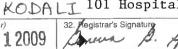
31. Date filed (Month, Day, Year) State

RAO

29a. Certifier

(Check only one)

Medical



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D67788

29d. Date signed (Month, Day, Year)

9.18:2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name *(First, Middle, Last)* Mary E. Massey Month 16/2009 Year 20:46рм Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner Montgomery Park, MD Washington Adventist Hospital Tacoma If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 82 Yrs 6. Sex **Funeral** Months Days 241-32-5239 1 □ M 2 🕅 F 19,1927 Wilson Co.,NC May Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 □ No Wilson Director NCWilson 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A 27893 308 Tacoma Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: Black 1 ☐Yes 2 No Specify \$ 3 Widowed 4 □ Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Museum Building Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Simms ပ္ Lonnie Hoskins 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5023 Riverdale Rd. #408 Riverdale, MD 20737 Daughter Paula Massey 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Rest Haven Cemetery9/26/09 Wilson, NC 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of FacilityEdwards Funeral Home 805 East Nash St. Wilson, NC 27893 21. Signature of Funeral Service Littenses Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse wence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a conse Examine law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate has 200 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: No 1 Inpatient 1∏Yes 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Checi one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Dr. Kango Nasreen
31. Date filed (Month, Day, Year) SEP 2 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7701 Carrol 32. Régistrar's Signature

Ave.

	_	For State		State o	of Mar	yland / I		rtment of tificate of		nd Me		iene eg. No.		1 313	£ 4	
	1. Decedent's Name (First, Middle, Last)									2	2. Date of Deat	h	Vee	3. Time of De	ath	
Physicia /Medic		JAMES EDWARD MOORE									Month SEP 9	2009	Year	1:09 P	M	
Examine		4a. Facility Name (or Location of	Death			ounty of Dea									
é «		NA	BETHESI		9 Date of Birth		IONTGOI		oreian							
Funeral Director		283-30-8050 ¹ X ^{M 2□ F}				(In yrs. last bi	Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day)		9. Birthplace (State or F Country) Ohio				
and	ŀ	Usual Residence of 10a. State	f Decedent 10b. County		1	0c. City, Tow	n or Loc	ation						10d. Inside City I	_imits	
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ո the r 28 a	Director	10e. Street and Nu	mber					10f. Zip Code	_		1	0g. Citize	n of What C	ountry?		
th with	la D	10415 Pearl Street				22032						USA				
tems	Funeral	11. Marital Status		12. Was Dec Armed F	orces?	/er in U.S. 13. Was Deceden If Yes, specify			f Hispanic Origin? (Specify Yes or No Iban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.				
filed within 72 hours after death with the Maryland Higiene. The stan "natural", or items 23a or 28a-f show after than "natural", or items 23a or 28a-f show ant, the Modicel Examination.	ρ	1 ☐ Never Marr 3 ☐ Widowed	2∐No ive Dates:	1959- 1979	1	1 □Yes 2 No Specify:				Specify: White						
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filed I Hygi other ent, II		17. Father's Name	(First, Middle,						18. Mother	r's Name	(First, Middle,	Maiden S	urname)			
uld be Venta rrked		Russel	ll Moo	re					Edna	a Mc	Gee					
2 sho and is ma rauma		19a. Informant's N		ship <i>(Type. Print)</i> oore/Wif		ł.		g Address <i>(Stre</i> 5 Pear								
1 and Healtl em 27		20a. Method of Dis		OOLE/WIL		001 51	10'	18' a /8 /a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a a	1				220 ation - City o	Town, State		
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		23a. Part 1. Enter i	the disease, or	r complications that t only one cause on	caused the	ne death. Do	not ente	er the mode of d	ying, such as	cardiac or	respiratory ari	est,		Approximate Interval Betwe		
Physician		Immediate Cause disease or condition	(Final on	only one cause on		SEPSTS								Onset and Dea	ath	
/Medical Examiner		resulting in death) Due to (or as a consequence of):														
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ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.														
Cause (Disease or Injury that initiated events resulting in death) Last Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):																
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eath certi aftending for use a	n/Me	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, ou			h 2	Tetania progna	nov			23	3d. Date of d			
ed for	Physician/M	23b. Was december pregnant in the past 12 months? 1										Month	Day Ye	ar		
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Physi this a	<u>۲</u>	1 ☐ Yes 2 ☐ 27. Manner of Dea			Inpatient of Injury	2 ER/C	utpatien Time of	it 3 DOA			ne 5 Resid			ecify)		
th. : After	tion	1 Natural	5 Pendir	ng (Mo.	nth, Day,		Injury	N N	ork? □Yes 2□1		da. Describe ii	OW INJURY	oodanod			
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Cottomised 28e. Place of Injury - At home, farm, street, factory, office 28f.									8f. Location (S City or Tow	f. Location (Street and Number or Rural Route Number, City or Town, State)				
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he Ho in 24 h he Fui ipletely	Medical	(Check only one)	2 Medical	I Examiner: On the	basis of e	examination a	and/or in	vestigation, in m	y opinion, dea	th occurre	ed at the time,	date and	place, and di	ue to the cause(s)		
To t To t	Σ	29b. Signature and	d title of certifie	er	MD				ense number	0 /==		29d. Date signed (Month, Day, Year)				
12		30 Name and add	trose of norma-	n who completed cau	ise of doc	ath (Itom 220	\ (Type		123554					/		
						MC US					VAL MED 20889-		CENTE	11/		
Stat		31. Date filed (Mor	nth, Day, Year,) * <u>3</u> 2.	Registrar'	's Signature	_			لطنده						
Registra	ar	3E	P 22	2009 Den	Bul.	A. 1	TO CHA	See .								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea, No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death

4b. City, Town, or Location of Death

Laurel

3. Time of Death

9:20 P

SEPT. 13, Day 2009 Year

4c. County of Death

PRINCE GEORGES

Physician
/Medical
Examiner

LOUIS

4a. Facility Name (If not institution, give street and number)

RAYMOND MATTHEWS

28a-f show and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Modical Examiner must be notified at filed within 72 hours after death with permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event

3altimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed P.0. signed by the a of Vital Records, this Division

Cherry Lane Nursing Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 3 M 2 F 212-34-2637 Maryland May 6, 1936 Director 73 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. Count 1 □Yes 2 □XNo Director Laurel MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12808 Golden Oak Drive 20708 II.S.A. Funeral 14, Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Never Married 2 X Married Black 1 □Yes 2 XNo Specify þ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) R & B Paving Elementary/Secondary (0-12) College (1-4or 5+) Company 11tn Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Eva Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Matthews (Wife) 12808 Golden Oak Drive, Laurel MD 20708 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBu 2 ☐ Cremation 3 ☐ Removal from State MD Nat'l Mem Park 9/19/09 Laurel, MD 4 D ation 5 Other (Specify 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. of Funeral Service 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or conshock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 Months 100 100 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Diserto for as a ponsequence offi Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 Z No 2 1 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred after death. Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier

State Registrar

Hospital

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛴 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year 1009 Physician/ EI MER EVERETT MOWEN Month 1158 AM Septembe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Vashington County 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖳 M 2 🗆 F Days Hours Min 182-22-6386 Months 81 Director Pennsylvania June Usual Residence of Decedent 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington Co. Hagerstown 1 Yes 2 TiNo 10e. Street and Number 10g. Citizen of What Country? 1714 Howell Road Funeral U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced and Mental Hygiene.

s marked other than "natural umatic event, the Medical E) Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Mason/Carpenter (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Clinton Mowen Orpha V. Johnston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Beth Mowen /Daughter 309 1/2 North Davis Street, Keyser, WV 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cedar Lawn Mem Park Sept. 24,2009 1) Burial 2 Cremation 3 Removal from State Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 331 Easte<u>rn Blvd. N. Hagerstown, MD</u> 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gestrontestad Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Bleeding (Aut me chance Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Contilopeth Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Renal Fullute Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 4.6.01 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy isespiretury Forly-8 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? P 1 Yes 2 1 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) CZ 9/20/ B38764 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagariloun MD 21742 TIVA Rid 1.t. 127 216665 bom cilli KARI **2** 2009 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1903 uth E. Means-Grove 2009 Sept 17 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Maryland Baltimore University of Maryland Medical Center Baltimore City If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 F Hours 1945 West Virginia 234-72-3446 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 1 ☐ Yes 2XXVo Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 11809 Patrick Road 21742 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 M Married 1 □Yes 2 XX Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Sales **1**2 Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hunter Doolittle, Jr. Eva William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hagerstown, MD 21742 11809 Patrick Rd. Dennis W. Grove - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Smithsburg Crematory 09-19-2009 4 □ Donation 5 □ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Osborne Funeral Home, P. A. 21. Signature of Funeral 5 425 S.Conococheague St. Williamsport, MD 21795 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hronic Obstructive Pulmonary Disorder 30 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for an a consequence of: Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 2 Accident

/Medical Examiner requires that the death certificate be executed burial-trans attending physician P.O. Box 68760 as the t for ed by the detached f signed t Division of Vital Records,

icate has been si page 2 should b

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics

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To the P. Within 2. To the P. Complet

npletely filled in by the

Physician

Physician

/Medical

Examiner

Director

Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ite Ma

72 hours after

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed

Be

Certification: To

Medical

State

23b. Was decedent pregnant

5 Pending investigation

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of pertifier

29c. License number 1972738805 29d. Date signed (Month, Day, Year) Sept. 17, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD

22 South Greene St., 31. Date filed (Month Day,

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Vear Month MARTIN LEWIS KEITH September 29. 2009 8:16 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Greater Baltimore Medical Center Towson Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min Months Days Hours 1 X M 2 ☐ F 214-62-9650 /26/1954 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 □ No Baltimore MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 United States 625 Hubner Street Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2**X** No Specify Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Container Repairman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Holmes Martin Helen Lewis Easton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Charles K. Martin (Brother 2014 Schuster Rd. Jarrettsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 9/30/2009 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland Approximate Interval Between Onset and Death 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Queek disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Ener Uncerlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify)

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be execute and

Physician

/Medical

Examiner

Director

Funeral

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Completed

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death with the Maryland

21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination and Leavent, eavent, If a Medical Examination and Leavent, If a Medical Examination and Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leavent Leaven

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Examiner cian/Medical

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Complet					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No			
ě	25. Was case referred to medical			26. Place of De	eath (Check only one)				
2	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	BR/Outpatient 3 □	DOA Other: 4 Nursing	ig Home 5 ☐ Residence 6 ☐ Other (Specify)				
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred			
on land	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ome, farm, street, factorify)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,			
alcal		Physician: To the best of my knaminer: On the basis of examin and manner stated.							

29c. License number

D58639

(0701 N. Charles St Boutimone MD 21204

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifie

30. Name, and address of perso

31. Date filed (Mq

completed cause of death (Item 23a) (Type, Print)

Print in Black Indelible Ink. Ensure All Copies Are Legible.

lease 1	Type or Print in	Black Indel	ible ink. En	Isure An C	obies vie
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Villiam Abner Mc		ker St For State	ate of Ma	ryland /	Depar Cert	tment of ificate of	Health Death	and	Menta	ıı rıygıe	Reg	No.	
Physiciar		egistrar Decedent's Name (First, Midd	le,Last)							2. Da	ate of Death	Day Year	3. Time of Death 2257 hrs
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	4	a. Facility Name (if not institution	on, give street a	ind number)		41	City, To		cation of I	Death		Washington	
		3406 Western Pike			/I: I-	at high dout	If Under		If Under	24Hrs. 8. I	Date of Birth	(MM/DD/YYYY) 9.	Birthplace (State or
Funeral	5	. Social Security Number	6. Sex		e (in yrs. ia:	st birthday)	Months	Days	Hours			LEOI	reign Country) PA
Director		217-88-7283	1 X M 2	F		32 Yrs.				110	arch -	1,13	
*	_	Isual Residence of Decedent Oa. State 10b. County			10c City.	Town or Location	on						10d. Inside City Limit
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		3406 Western	_	as Decedent	Ever in II	s I 13 Wa	s Deceden	of Hisp	anic Origin	n? (Specify	Yes or No-		merican Indian, Black,
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed by	17. Father's Name (First, Midd	le, Last)									laiden Surname)	
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		Robert C. McCu	isker/Gi	randfa	ther						ate	D 21750	ty or Town, State
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Box 68760 e death certificate be the attending physical for use as the buse	Physician/M	23b. Was decedent pregnant past 12 months?	n the	Live birth	at time of o		etal death	3	Ectopi	c pregnanc	у	Mona	
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the tart death. al Director: After this certificate has been signed by ited in by the funeral director, page 2 should be detacht.	þ	Tartii. Other signimount oo									1 Y	es 2 🗸 No 3	Probably 4 Unknown
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VISI or At fler d Direct in by	<u>`</u> <u>;</u> ë	3 V Suicide 6	Could not be	28e. Place of	f Injury - At	home, farm, st	treet, facto	y, office	building,		or Town	, State) ern Pike , Hancoo	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Certification:	4 Homicide		(Specify) F			-						
Hosi 24 hc Fun	<u>a</u>	29a. Certifier 1 Certifyin	ng Physician:	To the best of	f my knowl	edge, death oc	curred at the	ne time, i ny opinia	date and p on, death o	olace, and coccurred at	the time, da	use(s) and manner te and place, and d	ue to the cause(s)
o the athin o the o the omple	ledical		and	the basis of e manner state	ed.	anu/or mvesti			nse numbe			29d. Date sign	ed (Month, Day, Year)
- * - 5	Įξ	29b. Signature and title of co							.M.E.			September	
			, vo					<u> </u>	,.IVI.⊑.				
	1	30. Name and address of pe	erson who comp	leted cause	of death (It	em 23a)			MDO	1201			
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5 V		Ling Li, MD Ass	istant Medi	200	ner 1 strar's Sigr	11 Penn St	reet, Ba	timore	, IVID 2	1201			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 3. Time of Death 2, Date of Death 1. Decedent's Name (First, Middle, Last) Month 07401AM 26-2009 09 MILLER 4c. County of Death 4a. Facility Name (If not institution, give street and number) WASHINGTON HAGERSTOWN ENFILMARI If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) WV 8. Date of Birth (Month, Day, 02/07/ 7. Age (In yrs. last birthday). 72 Yrs. 5. Social Security Number 1 🛛 M 2 🗆 F 236-62-0430 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2X No MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21746 18601 Roxbury Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 Ø No Specify: If Yes, Give 56-61 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) WV Dept.of Health Social Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marian Mabel Hardesty Joseph Phillip Miller, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 160 Lambert Lane Aurora, WV 26705 Carolyn Miller/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XX urial 2 ☐ Cremation 3 ☐ Removal from State Accident Cemetery 9/28/2009 Eglon, * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rinkie Ad Pure Tal Home, Inc. .xcott PO Box 186 Davis, WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCE COLOW Due to (or as a consequence of BOWE OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY 1 Yes 2 No 3 Probably 4 Unknown ARTERY DISENSE PULMONING DISCHE 24a. Was an autopsy performs CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 28b. Time of Injury 28c. Injury at Work? 5 Pending

Physician /Medical **Examiner**

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records,

or Attending Physician:

To the Hospital

death.

Physician

/Medical

Examiner

Funeral

Director

28a-1 ehov

Directo

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Completed

or than "natural", or Items 23e or 28a-f ehove the Medical Examiner relations as

filed within 72 hours after

Pages 1 and 2 should be

al Hygiene.

f Health and Mental Hyg item 27 is marked other other traumatic event,

Department of Health ar important: If item 27 is any injury or other trau once.

Maryland 21215-0036

Baltimore,

Examiner physician and the burial-transit Physician/Medicai attending p for use as as by the a signed I ģ been si should t Be Completed page certificate Certification: To After the within 24 hours after death To the Funeral Director: , completely filled in by the f

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifie

1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ol death (Item 23a) (Type, Print) 30. Name and address of person wh

ROAD, HASERSTOWN MD21746 8601 ROXBURY COLIN OTTE 31. Date liled (Month, Day, Year)

State Registrar

Medical

investigation

6 Could not be determined



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Sta Registr	
OHMH 17 Rev 1/2	001

	1 - State Registrar 1. Decedent's Nar	me (First, Middle	e, Last)		Ce	uncale	of Death		2. Date of D		6 21 GH 19		3. Time of Dea
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al er			n, give street and nu		or.	4b. City, Tov	wn, or Location	of Death	вере		c. County of	Death	J. 1011
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	5. Social Security		6. Sex 1 XM 2 ☐ F	7. Age (In yrs.		If Under 1 Y Months D	Year If Under Days Hours	r 24 Hrs. Min.	8. Date of B (Month, D	<i>lay, Year</i>)	Country	_
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	10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						10d.	Inside City Li
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Director	10e. Street and N	umber				10f. Zip Co	ode			10g. C	itizen of Wha	at Country	?
	9226 G	ue Road					0872				U.S	.A.	
Funeral	11. Marital Status		Armed Fo		S. 13.	Was Deceden If Yes, specify	nt of Hispanic O Cuban, Mexica	rigin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - Black,	American White, etc.	
by F		rried 2 X Marı 4 □ Divorced	If Yes, G	ive		1 □ Yes 2 💆	No Specify	<i>/</i> :			Specify:	rm	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009 Physician 15, 1:16 A M SEPT. GENEVIEVE KINGSBURY O'CONNELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY BROOKE GROVE NURSING CENTER SANDY SPRING If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, SEPT 7 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 □ M 2 🛛 F 1918 ΜĎ 91 577-10-5021 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it a Medical Examination and page. 1 Yes 2 □ No Director OLNEY MD MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20832 USA 17808 HOWE DRIVE Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWIFE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAUDE WAGNER JOSEPH MANNING KINGSBURY ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17808 HOWE DR., OLNEY, MD 20832 MAUREEN DOYLE / DAUGHTER 9/16/09 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FREDERICK, MD STAUFFER CREMATORY 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, 20838 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DAYS **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 □Yes 2 □ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown MEUMONIA, DIABETES Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ! 2 No 2 1 NO 1 🗌 Yes 1 ∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1º Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation

The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

with the Maryland

filed within 72 hours after death

Pages

Baltimore, Maryland 21215-0036

28a-f show

State

Medical

31. Date filed (Mont Registrar

10301

2 Accident

4 Homicide

29b. Signature title of certifier

3 Suicide

29a. Certifier (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 00057630

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

MEORGIA

SILVER SPRING, ND 20902

Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Powell 2:45 p.M Joseph Lester 2009 September 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Dorchester General Hospital Cambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 30, 1943 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F Georgia 260-64-0690 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me ical Examiner must be notified at MD Dorchester Cambridge 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5415 Morris Neck Road 21613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) public relation executive government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Lester Powell June Williamson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nan Powell wife 5415 Morris Neck Rd., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 9/16/09 Salisbury Crematory Salisbury, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee DCK. B 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed Exami burial-trar Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the l ase IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for L in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? Division or Vital Records, 2 □ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate Physician: 25. Was case referred to p examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 TYes 1 Inpatient 2 PR/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Attending atural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determine 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Hospitai 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Alan D Moore, MD 31. Date filed (Month, Day, Year) **SEP 17**

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

300 Dorchester

29c. License number

tvenue

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Cecil Co. 9/22/2009 Amend Item For 126 Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** \mathbf{F}^{M} 18 2009 9:16 Sept. Mary Elizabeth Feck /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil E1kt.on Union Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year) Days Months Hours 1 □ M 2 🗓 F 12, 81 1928 New York Apr. 067-22-6485 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 1X Yes 2 □ No traumatic event, the Medical Exeminer sust be notified Director Maryland E1kton Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 23a 21921 3007 Spanish Bay Ct. Funeral 72 hours after death items / Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 X No Specify. Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) Own Home Homemaker is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Kathleen Harvey ပ Joseph Clancy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 2.5 Important: If item 2.7 is m. any Injury or other to once. 19a. Informant's Name/Relationship (Type. Print) 3007 Spanish Bay Ct., Elkton, John Harvey Peck /Husband 21921 MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition $9-23^{Date}$ 1 X Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Delaware Veterans Cemetery Bear, Delaware 21. Signature of Service Licensee 22. Name and Address of Facility R.T. Foard and Jones, Inc. 122 W. Main St., Newark, D W. Main St., Newark, DE 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. Approximate Interval Between Onset and Death Immediate Cause (Final evelworm when **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ar Cop a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Out to for an a consequence of) Examine be executed 18 m and burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the 1 law requires that the death certificate as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ģ in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by to be a becaused to be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? AND 24a. Was an performed? 1 □Yes 2 □ No certificate 1 ☐ Yes 2 ☑ No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 2 100 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of njury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Prospital or Attending Prospital or Attending Prospital 24 hours after death.
Funeral Director; After the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the structure of the st filled in by To the Hospital of within 24 hours a To the Funeral D completely

30. Name and address of pe 6

31. Date filed (Month, Day, Year) State SEP 2 2 2009

rson who completed cause of death (Item 23a) (Type, Print) BRAIL

and manner stated.

Witt

32. Registrar's Signature

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2 000 3131

2600 Christon Du

29d. Date signed (Month, Day, Year)

4b. City, Town, or Location of Death

2. Date of Death

Day

September 17, 2009

4c. County of Death

January 13, 1936 District of Columbia

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death

Harriette Kaminsky Plotkin

1. Decedent's Name (First, Middle, Last)

Physician

/Medical

**	1	0	2
1	i	U	U

3. Time of Death

1647

Montgomery Birthplace (State or Foreign Country)

M

Tall admity frame (in free free free free free free free fre	and number)	4b. City, Town, or Lo	cation of Death	40.	4c. County of Death			
Casey House			ckville		Montgomery			
Social Security Number 6. Sex	7. Age (In yrs. last bir	Months Days	Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)			
578-46-5380 1□ M 2	73	Yrs.	Ja	nuary 13, 1	936 District of Columb			
Usual Residence of Decedent								
10a. State 10b. County	10c. City, Towr	or Location			10d. Inside City Limit			
Maryland Montgome	rv	Roc	ckville		1 ☐ Yes 21x N			
10e. Street and Number	- 7	10f. Zip Code		10g. Cit	tizen of What Country?			
	od #115		20052		U.S.A.			
The second				/ Vas or No-	14. Race - American Indian,			
Ar	med Forces?	If Yes, specify Cuban,	Mexican, Puerto Rica	an, etc.)	Black, White, etc.			
_ If	Yes, Give	1 □Yes 2 No 3	Specify:		Specify: Caucasian			
				405-14				
15. Decedent's Education (Specify only highest grade com		(Give kind of work done duri	on ing most of working	16b. K	find of Business/Industry			
Elementary/Secondary (0-12)					0 7			
	1				Own Home			
17. Father's Name (First, Middle, Last)		18	B. Mother's Name (Fi	irst, Middle, Maider	Surname)			
Nathan Kaminsky			Ma	ry Aronstei	in			
19a. Informant's Name/Relationship (Type, P.	rint) 19b	. Mailing Address (Street and	d Number or Rural R	oute Number, City	or Town, State, Zip Code)			
		22 Bromorton Dri	vo Croonvil	lo North (Parolina 27858			
					ocation - City or Town, State			
	cemete	ry, crematory or other place)						
4 Donation 5 Dother (Specify)		Memorial Garden	s 09/21/2	2009	Olney, Maryland			
21. Signature of Funeral Service Licensee		22. Name and Address	of Facility	d Too				
Torna L	Wou 143	11800 New Ham	pshire Avenu	e. Silver S	Spring, Maryland 20904			
Sequentially list conditions b.	Osteomyelitis Due to (or as a consequence	of):						
in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day Year			
Part II. Other significant conditions contribute	ting to death but not resulting it	n the underlying cause given	in Part I.	23e. Did tobacco	use contribute to the cause of death?			
Sleep Apnea				1 ☐ Yes 2	Probably 4x Unknov			
					1			
Diabetes Mellitus Chronic Back Pain				24a, Was an autopsy performed? 1 ☐ Yes 2 ☒ No	24b. Were autopsy findings availab prior to completion of cause o death? o 1 □ Yes 2 □ No			
25. Was case referred to medical			26. Place of Death (C					
		26. Place of Death (Check only one) Other: Other: A Description of Florida (Check only one)						
examiner?	al: 1 □ Innationt 2 □ FR/O	Itnationt 3 DOA Other:	28b. Time of linjury Work? 28d. Describe how injury occurred work?					
examiner? 1 ☐ Yes 2 🕱 No Hospit	a. Date of Injury 28b.	Time of 28c. Injury a lnjury	4 LI Nursing Home					
	Maryland 10e. Street and Number 11430 Strand Ro. 11. Marital Status 1	Maryland Montgomery	Maryland Montgomery Ro	Maryland Montgomery Rockville	Maryland Montgomery Rockville			

Ichou

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 🗷 No eath (Check only one) Hospice Home 5 ☐ Residence 6 X Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) ace, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) September 18, 2009 Jocelyne Toukep Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20855

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

j. Kouel

29c. License number 163748

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AUG. 30°-2009 7:05A M SARAH LUCILLE PEARSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY Holy Cross Hospital Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not be not 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2🔀 F 85 215-76-5180 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Baltimore MD Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21227 4021 McDowell Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. d 2 should be filed within 72 hours after th and Mental Hygiene.
7 is marked other than "natural", or ite traumatic event, the Medical Evanting 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No ò Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Food Service Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Be Evelyn Waiter Smith 19a. Informant's Name/Relationship (Type. Print) (Daughte/Is)b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4021 McDowell Lane, Baltimore, MD 21227 Joane Pearson-Taylor 20b. Place of Disposition (Name of cemetery/crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from pe Ch. Cem. 9/23/09 Silver Spring, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 4 Donation 5 ☐ Other (Specify) $H\phi$ pe Ch. Cem. of Funeral Service License 246 N. Washington St, Rockville MD 20850 ons that caused the death. Do ot effer the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disea e, or complic shock, or heart failure. List only or Immediate Cause (Final **Physician** disease or condition resulting in death) COPD /Medical Due to (or as a consequence of): Examiner Respiratory Failure
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be a toous after death.

Nous after death.

If the class of the this certificate has been signed by the attending physician reral Director. After this certificate has been signed by the attending physician reliand in the functional director, page 2 should be defacted for use as the buring this page. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2√ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ∐Yes 2 No Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 8/31/09 D67589

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

of Vital Records.

Division

1500 Forest Glen Rd, Silver Spring, MD 20910 Harold V. Lawson, M.D.31. Date filed (Month, Day, Year) 22. Registrar's Signature 2 2 2009

30. Namy and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Isabelle Pasternak ember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F June 4,1920 Marvĺand Director 89 216-16-9308 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State West 10b. County 10c. City. Town or Location 1 ☐ Yes 2√∑ No Director Falling Waters Virginia Berkeley 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a 27 Jericho St. 25419 USA Funeral 1 and 2 should be filed within 72 hours after death. Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ May Evelyn Blakemore <u> Clarence Edward Frazier</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 25419 Stephen Pasternak-Son 27 Jericho St. Falling Waters, West Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation Removal from State 5 □ Other (80ecity) 4 ☐ Donation Cedar Lawn Mem. Park Sept.23,2009 Hagerstown, Maryland 21. Signature of Funeral S Osborne Adress of Fally Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Se PSI disease or condition resulting in death) /Medical Mladder Due to (or as a consequence of): Examiner Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DNo 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 Yes 2 🗆 No reral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funeral D

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and title of certifier

-ARIP

MURSHE D 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s).

29c. License number

DO60396

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene [] [] []

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			23a. Pert1. Enter the disease, or companies shock, or heart failure. List only	plications that caused	the death. Do	not enter	the mode of dy	ing, such as cardia	ac or respiratory ar	rrest,		Approximate Interval Betw	veen
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<u>s</u>	Attending or death. actor: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be]Yes 2□No	006 L	Street and Numb	or or Pur	I Davido Numi	har
Division	or At after of Direct in by	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc		rarm, stree	et, ractory, office	•	City or Tou	vn, State)	er or nura	II FIODIO I VOITE	, Jei
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	To the Hospital or Attending Physician: The is within 24 hours effer death. To the Funeral Director: Affor this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	and mariner sta			29c. Licer	nse number		29d. Date signe	d (Month	Day, Year)	4
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	6		30. Name and eddress of person who	completed cause of de	ath (Item 23a)	/ (Type, P	MM A	UT 15	·~~~	Ich 1	ND		
	Sta	te.	31. Date filed (Month, Day, Year)	32 Registre	or's Signature	7 4 (,,,						
	Registr		SEP 17 200		_ A.	box	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 1519 September 19 2009 endell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Dorchester General Hospita Dorche Ster Cambridge 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 102 M 2□ F Days 219-42-8'76 Usual Residence of Decedent Maryland June 20,194 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? USA by Funeral enburn Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Black 1 ☐Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Appliance Compan 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelun 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or R all Route Number, City or Town, State, Zip Code) Easton Mary/and 2/60/ 20c. Location - City or Town, State shortal 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Royal Oak Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P. A. 510 washington Str Cambridge 23a. Part Inter the disease, or complications that caused the deh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SLOCIL Septic Due to (or as a consequence of): Intra a belowiner abscess Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 → NO 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2 4NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐Yes 2 1€ Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident

the death certificate be executed burial-transit and P.O. Box 68760, signed by the attending physician I be detached for use as the buria Division of Vital Records, certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Funeral

Director

28a-f show

items 23a or

'natural', or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than 'amy Injury or other traumatic event, the Means.

Physician /Medical

Examiner

the Medical Examiner must be notified at

Juld be filed within 72 hours after death with the Mental Hygiene.

Baltimore, Maryland 21215-0036

Ross, Wende

6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29c. License number

CAMORINGE

29b. Signature and title of certific

D47924

29d. Date signed (Month, Day, Year) 9.20.09

2/6/3

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) BYRN 503 NOMAN THANWY

and manner stated

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 23

32. Degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert William Roxburgh 2009 Sept. 18 12:08 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital E1kton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1**X** M 2□ F 24, Director 82 058-20-5185 Dec. 1926 New York Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shovidical Exemples in ust be notified at Director 1 ☐ Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene.
em 27 is marked other than "natural", or items 23a or 50 Farah Dr. 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No If Yes, Give Year or Dates: Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Signe Marker ٩ Richard Roxburgh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Facciolo/Daughter 50 Farah Dr., Elkton, MD 21921 permit. Pages 1 a
Department of Hea
Important: If Item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 9-22-2009 Chesapeake City, MD 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A.
318 George St., Chesapeake City, MD 21. Signature of Funeral Service Licenses 21915 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** archio resti /Medical Due to (or as a consequence of): Examiner 2515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to for as a consequence of): executed Exami \Diamond and burial-tran Due to (or as a consequence of): attending physician Attending Physician: The law requires that the death certificate be Physician/Medical abetes IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Yea 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate me 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**V** No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred s after dea. ral Director: Aff 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide ō To the Hospital within 24 hours a To the Funeral (Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dr. Muhammed Niaz,

266 South College Ave., Newark, DE

0059501

29d. Date signed (Month, Day, Year)

8

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

,			For State Registrar 1. Decedent's Name	e (First, Middi					rtificat				lental Hy	Reg. N	lo.		3. Time of	Death
	Physici /Medic		Dennis Da	vid Redw	ay								Month Septemb	ber	²⁰ 20	^Y ear 2009	3:00	
0	Examin		415 Patriot	ts Way	n, give street and nu	umber)			Elkt	on	r Location			4	c. County Cecil	of Death		
P	Funeral Director		5. Social Security N 097-84-04	84	6. Sex 1 ☑ M 2 □ F	7. Age 48		ast birthday) Yrs.	if Unde Months	1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of B (Month, D July 28,	irth ay, Yea 1961	r)	9. Birthplac Country	Jama	_
	/aryland f show ed at	or	Usual Residence o 10a. State MD	10b. County			10c. City	Town or Lo	ocation							100	. Inside Cit	
	with the Na or 28a-	Direct	10e. Street and Nu 415 Patriot	mber					10f. Zig				-	_	Citizen of V	What Country	?	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Marr	ried 2 Mar	If Yes, G	orces? 2 No ive	,		Was Dece	dent of H cify Cuba	lispanic Or an, Mexica Specify	an, Puerto	ecify Yes or N Rican, etc.)		14. Rac	e - American ck, White, etc		
Baltimore, Maryland 21215-0036	iin 72 hou n "natura Medical Es	Completed I		15. Deceder cify only highe	nt's Education st grade completed)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occup rk done o se retirec	eation during mo: d)	st of work	ing	16b.	Kind of Bu	usiness/Indus		
ld 212	s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medical	Be Com		2	College (3	-)	Carpe	nter		18. Moth	ner's Name	e (First, Middle		onstruc			
/lan	should be and Mental s marked o umatic eve	To B	David Red	way							Pear	rline H	arrison					
, Man	es 1 and 2 sho of Health and item 27 is ma rother trauma		19a. Informant's N Hermin Herman Re						ng Address Patriots				al Route Numi 21921	ber, City	or Town,	State, Zip C	ode)	
more	6 O			☐Cremation	3 Removal from	State	ce	ace of Dispo metery, cre	matory or o	ther plac			Date			City or Town		a
Balti	permit. Pag Department Important: I any injury o once.		4 □ Donation 5 □ Other (<i>Specify</i>) Redway Family Cemetery October 5, 2009 Browns Town 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton.															
	Physician /Medical		Immediate Cause (Final													pproximate iterval Betv inset and D	veen Peath	
	Examiner	niner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	enditions, nmediate erlying	b	(or as a	conseque	ence of):								4:		
8760,	cate be executed ohysician and the burial-transit	dical Examiner	that initiated events resulting in death) i	6	c. Due to	(or as a	conseque	ence of):										
Division or Vital Records, P.O. Box 68760	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? ⊒No		birth 2 nant at t	f pregnar P⊟Fetale ime of de	death 3	□Ectopic pi □Other <i>(sp</i>		,					te of delivery	ay Y	ear
rds, F	quires tha en signed uld be det	þ	Part II. Other signi	ficant conditi	ons contributing to c	leath but	not resul	ting in the u	nderlying o	ause give	en in Part	I.				ribute to the		eath? nknown
ital Reco	cate has page 2	Be Completed	25. Was case refer	red to medica	L						26. Place	e of Death	24a. Was auto perf 1 Yes	opsy formed? 2 X N	24b.	Were autops prior to comp death? I □ Yes 2	/ findings a letion of ca ✓ No	vailable use of
or V	hysicl this ce	၉	examiner? 1 ☐ Yes 2 ☐					R/Outpatier			er: 4□Ni		me 5 Res		6 □Oth	er (Specify)		
sion (tending Fleath. tor: After the funer	Certification:	27. Manner of Deat 1 Natural 2 ☐ Accident 3 ☐ Suicide	h 5 ∐ Pendin investig 6 ∐ Could i	gation	nth, Day	Year)	28b. Time o Injury	М		yat k? Yes 2□]No	28d. Describe					
Divi	oltal or Al urs after of sral Direc illed in by		4 Homicide	determ	ined 28e. Place build	ling, etc.	(Specify)						28f. Location City or To	own, Sta	te)			per,
	thin 24 hor the Fune mpletely fi	Medical	29a. Certifier (Check only one) 29b. Signature and	1 Secretifyir 2 Medical Little of certifie	g Physician: To the Examiner: On the band man	pasis of e	examinati	ledge, deat on and/or in	vestigation	, in my o	pinion, de	and place, eath occurr	and due to the red at the time	, date a	nd place,	and due to th	e cause(s)	
	N CO		Kól		> \			r	DI	000	S 644				9 6	21 O	y, rear)	
	5		30. Name and addr	9 im	who completed cau	my	ath (Item :	23a) (Type,	Print) 11191	, 5 ₁	1., 5	Suite	303	21	Kton	MO:	4921	
	Stat Registra		31. Date filed (Mon	EP 2 2	2009 &	registrar	s Signati	fa	الميل									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 **Physician** 2009 A M Royer, 4:40 James Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13425 Windsor Drive Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 08 04 Birthplace (State or Foreign Country) 5. Social Security Number .Sex 1**X** M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Year) Min. Days Hours 184-12-3993 87 PA Director 1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Mofinal Eventine" is the retified at any Injury or other traumatic event, the "Mofinal Eventine" is at bar retified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD 1 □ Yes XXNo Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13425 Windsor Drive 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) owner liquor store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thaddeus Garfield Royer Daisy Maude Holtzman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne L. Hale 13425 Windsor Drive, Hagerstown MD 21742 companion 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☒ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Green Hill Cemetery 10/01/2009 4 □ Donation 5 □ Other (Specify) Waynesboro, PA 21. Signature of Puperal Service License 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St., Waynesboro PA17268 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician entre disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner of as a consequence of lor Attending Physician: The law requires that the death certificate be executed burial-transit U Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Hospital 1 Certifying Physician: To the best of ryy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year,

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P.0.

Division of Vital Records.

State Registrar

Date filed (Month,

DHMH 17 Rev 1/2001

ORIGINAL

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medeellann

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LILLIAN September 13, SIMON 2009 6:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Sandy Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Oct. 14 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1917 1 □ M 2 150 F 579-14-7110 91 Yrs. Director Washington, D.C Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show item 27 is marked other then "neturel", or items 23e or 28e-f shot other treumetic event, the Modical Examinary and by political at Md. 1 ☐ Yes 2 No Montgomery Silver Spring Direct 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1108 Ednor Road 20905 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after a nand Mental Hygiene. Is marked other then "neturel", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Translator U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vincent DiGirolamo Amalia Chiera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an Linda Gilpin / Daughter 1108 Ednor Road, Silver Spring, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Z Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) 9/14/09 Metropolitan Crem. Alexandria, Va. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home 0. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer Years /Medical Due to (or as a consequence of): **Examiner** 5 Years Alzheimer's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death P.O. 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe Giant Cell Arteritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 StUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Division of Vital 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death | Check only one | examiner? Other: 41 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 3 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 43237 September 14, 2009

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

14201 Laurel Park Drive, #102, Laurel, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Paul Armstrong, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene []

	•	1 - State Registrar	Cer	tificate of	Death	F	leg. No.			
Dharia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th Day	Year	3, Time of Death	
Physici /Medi		Geneva Woodall Spray				Septemb			5:10 p M	
Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death		
-"		Chester River Manor 5. Social Security Number 6. Sex 7. Age (Ir	o uma lant hintholous	Chestert	OWN	T a Data of Birth	Kent		lace (State or Foreigr	
Funeral Director		1 DM 2VIE	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Da) 12/9/1	(, Year) 016	Coun	nace (State of Foreign htry) MD	7
		Usual Residence of Decedent	4			12/9/1	910		TID	_
yland		10a. State 10b. County 10	c. City, Town or Lo	cation				11	0d. Inside City Limits	
e Mai	cto	MD Kent C	hestertov	vn					1 □ Yes 2 ŪÑNo	_
₹ or ₹	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Coun	try?	
s 23a	eral	22 Warwick Rd.		21620		7. 17	USA		to the state of	_
ter de	Funeral Director	11. Marital Status 12. Was Decedent Ever Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ ZeNo	'in U.S. 13. V	Vas Decedent of F f Yes, specify Cuba	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ce - Americ ck, White, e		
ire, Maryland 21215-UU36 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medien Extrails an institled at	þ	3	1	□Yes 2XNo	Specify:		Specif	^{y:} Whit	ie.	
2 hou	Completed	15. Decedent's Education	16a. Deced	lent's Usual Occup	pation during most of work	ina	16b. Kind of B			_
thin 7	nple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired	during most of work d)	ing				
ed wi	Cor		Homen	naker				Home		
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth traumatic event	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			ne)		
arylan(should be f and Mental marked of umatic eve	은	Edward E. Woodall				Cochran		0	0.13	
Man d2sh d2sh d2sh an than traur		19a. Informant's Name/Relationship (Type. Print) Robert Spray/Son	144		Rd. Chest				Code)	
1 and 1 and Health tem 27			20b. Place of Dispos cemetery, cren			Date Date	20c. Location		wn, State	
		1 E Buriai 2 Cremation 3 C Removal from State			i	100	. .		100	
baltimo permit. Page Department o Important: If any injury or		21. Signature of Funeral Service Licensee	Chester C	. Name and Addre	9/25 ess of Facility		Chester			
o and be de		I Duck & Welfert	en F	ellows, F 30 Speer	Helfenbei Rd. Ches	n & Newr tertown.	am Fune MD 216	eral I 520	Home	
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	ī
Physician		Immediate Cause (Final disease or condition	iluora	Disea	10			•	Onset and Death	7
/Medical		resulting in death) a. Due to for as a co		10					4	2_
Examiner		Sequentially list conditions. b.								_
led isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ensequence of):							
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X b8 / bU, sertificate be executed ding physician and se as the burial-transit	Medical	u			-		-1			_
BOX sath cer attendin for use	-	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of p	regnancy	Ectopic pregnanc	24		23d. Da	ate of delive	ery	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1. Certifying Physician: To the best of m	y knowledge, death amination and/or in	occurred at the ti	ime, date and place	, and due to the	cause(s) and m	nanner as s and due to	stated. tate cause(s)	
the hin 2 the F	Medical	one) and manner stated		On Linean			and Data signs	d (Month	Day Your	_
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TM		30. Name and address of person who completed cause of death NRI Stadland MO	(item 23a) (Type, I	Print)	Jt. (Charte	town	M	21620	
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's	Signature			2010				_
Regist	rar	SFP 2 3 2009 Person	~ A. 1	back						
DHMH 17 Rev 1/2	2001		7	111						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 9:54 P WILLIAM BRUCE SEITZER, SR. SEPT. 2009 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTERTOWN KENT 7862 CARRIAGE LANE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1**X** M 2□ F 5/29/1929 PA Director 167-24-0907 80 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extravirer must be notified at once. 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director CHESTERTOWN MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7862 CARRIAGE LANE 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1XYes 2 □ No If Yes, Give Year or Dates: N/A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: WHITE Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 COMPTROLLER CORPORATE FINANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be H. BRUCE SEITZER ဂ္ FREDERICA FREY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA M. SEITZER/WIFE 7862 CARRIAGE LANE CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHREWSBURY CEMETERY 9/12/09 4 ☐ Donation 5 ☐ Other (Specify) KENNEDYVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 uch 23a. Part 1. Enter the disease, or complication that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of : Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a gonsecuence of) the death certificate be executed use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter 3 Ectopic pregnancy Por Month Day Year 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been si should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. I Director: After i d in by the funera After 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide To the Hospital o within 24 hours af To the Funeral D completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number

15

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who

Tathick S. & handhan, MD
31. Date filed (Month, Day, Year)
32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

120 SpeerRd. Chestertown, MD 21620

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 3. Time of Death **Physician** Ellsworth Shoemaker September 19, 2009 3:42 ₺ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday, **Funeral** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1**⊠** M 2□ F Months Days Hours Min 579-03-9947 93 **Director** Jan. 5, 1916 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it worden Eventral runt be notified at 1 ☐Yes 2KNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10406 Inwood Avenue 20902 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1944-46 1 ☐ Yes 2K No Specify ş Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygier is marked other the Motorcycle Officer U.S. Park Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be file if Health and Mental H item 27 is marked oth Be James Edward Shoemaker Florence Bricker ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Ellsworth Shoemaker, Jr./Son 10406 Inwood Avenue, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place)
Potomac United Methodist
Church Cemetery Pages 1 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 25, Potomac, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20902 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): attending physician Box 68760 The law requires that the death certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.0. the ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s 24a. Was an autopsy certificate 2 **N**o Division of Vital 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Jepital o.
4 hours after de.

**ral Director: An.
'in by the fur 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hou₁ the Funeral Dire To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 5 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D62432 September 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Holley C. Meeks, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

2. Registrar's Signature

			ForAmend Item 31 State of Maryland / Dep State Registrar WCHD/SH 9/18/09 per VR Ce	artment of F			giene Reg. No. 0	19	31847	
۳	12 2		Decedent's Name (First, Middle, Last)		Dou	2. Date of Dea	ath		3. Time of Death	
	Physici /Medic		Lela Berniece STRUBEL			Septemb	er 16, 2	Year 2009	4:38 a.™	
3	Examin		4a. Facility Name (If not institution, give street and number)		r Location of Dea		4c. County o			
A.		1	9 W. Douglas Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		nithsbur	~	Washington			
	Funeral Director		232-22-5554 1 M 2 X F 95 Yrs.	Months Days	Hours Min		, Year) 1914	Countr	ce (State or Foreign y) Virginia	
			Usual Residence of Decedent			, ,				
	arylar show	-	10a. State 10b. County 10c. City, Town or L					100	d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	the M 28a-f notifie	Director	Maryland Washington Smiths 10e. Street and Number	10f. Zip Code			10g. Citizen of W	hat Countr		
	3a or		9 W. Douglas Court	2178	13		USA	nat oddini	, .	
	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral		Was Decedent of H If Yes, specify Cub-	fispanic Origin? (Specify Yes or No-	14. Race	- Americar		
9	after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes. Give	1 ☐ Yes 2 ☒ No	Specify:	nto nican, etc.)	Specify:	k, White, et wh:	_	
Maryland 21215-0036	hours tural'	ed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occup	nation		16b. Kind of Bus	*****		
7.	in 72 n "na Medic	Completed	(Specify only highest grade completed) (Giv	e kind of work done DO NOT use retire	during most of wo d)	orking	TOD. RING OF BUS	3116227 H 100	istry	
212	d with giene er tha	mo	Elementary/Secondary (0-12) College (1-4or 5+) tea	cher			county	pub1:	ic school	
g	be file	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle,				
<u> </u>	Men Marker Marker Marker	٦ ک	Daniel Thomas Tharp			na Kate P				
Mai	d 2 sh th and 7 is n traun		* * * *	ing Address (Street 3 Woburn			-		,	
ō,	Healt Healt tem 2	1	20a. Method of Disposition 20b. Place of Disp	osition (Name of	i	Date Date	20c. Location - 0			
OE E	Pages ent of nt: If i		I X Burial 2 Cremation 3 Hemoval from State	ematory or other place en Cemete	· · · · · · · · · · · · · · · · · · ·	21/09	Hagersto	own. l	Marvland	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic es once.			2. Name and Addre			 FUNERAL			
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	ter the mode of dyir	ng, such as cardia	ac or respiratory are	rest,	Í	Approximate Interval Between Onset and Death	
4	Physician		Immediate Cause (Final disease or condition resulting in death)					7	onset and Death	
2	/Medical Examiner		Due to (or as a consequence of):							
	4000	er	Sequentially list conditions, if any, leading to immediate cause. Linet underlying Cause (Disease or injury							
	cuted nd ransit	Examiner	that initiated events							
Ö,	cate be executed oblysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):							
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9 X	death certific attending p	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			11127	Old Date	at deliver		
Вох	death atten	Physician/Me	1 Live birth 2 Fetal death 3 in the past 12 nonths? 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	<i>y</i>		Mon	e of delivery oth D	y Day Year	
o.	t the c by the ached	hysi	9 ☐ Unknown 9 ☐ Unknown	., ,,						
S, P	w requires that the do been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ren in Part I.		bacco use contri	bute to the	cause of death?	
ord	requir sen si			-		1 🗆 Y	es 2 No	3 Probal	bly 4 □Unknown	
Vital Records,	has be	Completed				24a. Was a	sy pi	rior to comp	sy findings available pletion of cause of	
<u>a</u>						perfor 1∐ Yes		eath? ☐Yes 2	2□ No	
	siclar certification	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Oth	or:	eath (Check only or				
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Ö	ath. or: After	atio	Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation		Yes 2 □ No					
Division or	ir Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	or or Rural i	Route Number,	
	oital ours afteral Derail Dilled in		Monthly Devices			1				
	Phospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fi	edical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the ti nvestigation, in my	me, date and place opinion, death occ	curred at the time,	cause(s) and mar date and place, a	nner as sta	ted. the cause(s)	
	To the Hospital or Attending Physician: Within 24 hours after death To the Funeral Directors After this certific completely filled in by the funeral director,	Med	29b. Signature and title of certifier	29c. Licens	e number	2	29d. Date signed	(Month, D	ay, Year)	
			(1) [(1)	.D	12145	7	9-17	7-9	gop.	
24	ا ا		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	md	21701)			
	Sta	te	31. Date filed (Month, Day, Kar) 32 Registrar Signature	2 TOWN	IIM	al 170	-			
	Registr		31. Date filed (Month, Day, SEP 18 32. Registrar Signature)	post						

		1 - State Registrar		C	ertificate of	Death	Re	g. No.	/5 4 1 0 5 5
		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month		3. Time of Death
Physic /Med		BURTON I	ERNEST	SHERMA	ΑN		SEPT.		009 11:20 PM
Exami		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Death	1	4c. County of	Death
		11650 STINES	STORE RO	AD	CHARL	OTTE HAL	,L	CHAR	LES
Funera			6. Sex 7. Ag 1 🖾 M 2 🗆 F	e (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
Directo		218-34-5207	IMAM ZLIF	72 Yrs			JUN.30,	1937	MARYLAND
pur *	7	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			-	10d. Inside City Limits
aryla sho	ក					T			1 □ Yes 2X XNo
he M	Director	MD CHARI	JES	CHARL		با	1 40	N= 0:4:=====4.04/b	
be filed within 72 hours after death with the Maryland tial Hygiene. Ido other than "natural", or items 23a or 28a-f show event, it a "valical Evyring, must be notified.	Ö	10e. Street and Number 11650 STINES	S STORE RO	AD	10f. Zip Code 206	22		ng. Citizen of What U。 S	
ns 23	Funeral	11. Marital Status	12. Was Decedent		3. Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Race -	American Indian,
fter o	F	1 Never Married 2 Marrie	Armed Forces? ad 1 ☐ Yes 2√		If Yes, specify Cub	ban, Mexican, Puert	o Rican, etc.)	Black,	White, etc.
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify:	WHITE
72 hours aft natural", or	Completed	15. Decedent's	Education	16a. De	cedent's Usual Occu	pation	1	6b. Kind of Busin	ness/Industry
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filed within Hygiene. other than "	9	8		SEC	URITY GU	ARD		PEPCO	
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should be filed within and Mental Hygiene. s marked other than umatic event, the files	2	ERNEST LYLE	SHERMAN			MARY	MELVIAN	NA GOLD	SMITH
au ar		19a. Informant's Name/Relationshi	p (Type. Print)	19b. Ma	ailing Address (Stree	t and Number or Ru	ıral Route Number,	City or Town, St	tate, Zip Code) 20622
and and m 27		SANDRA L. SHI	ERMAN/WIFE	116	50 STINE			ARLOTTE	HALL, MD
		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3	□ Domaval from State	20b. Place of Dis	sposition (Name of crematory or other pla	ce) OCTO	Date OBER 2009	0c. Location - Ci	ty or Town, State
oermit. Pages 1 a Department of Her Important: If Item any Injury or othe		4 □ Donation 5 □ Other (Spe		TRINIT	Y MEM.GR	DNS $\frac{1}{2}$ $\frac{2}{3}$	2009 _V	VALDORF	, MARYLAND
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Li	icensee		22. Name and Addr	ess of Facility R	AYMOND I	FUNL.SE	RVICE, P.A.
any per		Yory 18as	D D	M00641	5635 WAS	HINGTON	AVE.,LA	A PLATA	,MD 20646
		23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omplications that caused	the death. Do not	enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	MALS	FINANT	(a ner	NOTO.	1 DESCI	MECUNS	Onnot and Death
/Medical		resulting in death)	Due to (or as	a consequence of):					X Mowny
Examiner		Consentation for a confidence	h				0		
ted nsit	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
ecute nd trans	Examiner	Cause (Disease or injury that initiated events	c						
e exe		resulting in death) Last	Due to (or as	a consequence of):					
ificate be execute g physician and as the burial-trans	<u>2</u>		d						
.E 5, a	/Medical	IF FEMALE:						I	
		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		3 ☐ Ectopic pregnan	ncv		23d. Date	
e death c he atten	sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other (specify)			Month	h Day Year
The law requires that the death ate has been signed by the atter page 2 should be detached for L	Physician	9 Unknown							
res th	by	Part II. Other significant condition	is contributing to death b	ut not resulting in the	e underlying cause gi	iven in Part I.			ute to the cause of death?
w require been si should b	ted						1 ☐ Ye	s 2 □ No 3	☐ Probably Unknown
or Attending Physician: The law requires tarter death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed						24a. Was an	24b. We	ere autopsy findings available or to completion of cause of
The cate har page	ĕ						perform	red? dea	ath? □Yes 2□No
Physician: The rath certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		
physician: this certifical	2	1 Yes 2√No	Hospital: 1 ☐ Inpatie	ent 2 🗆 ER/Outpa	tient 3 ☐ DOA Ot	her: 4 \Bursing H	ome 5 Reside	nce 6 Other	(Specify)
ding Ph h. After thi funeral	ü	27. Manner of Death 1-21 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y, Year) Injur		ury at	28d. Describe ho	w injury occurred	
Attending or death. ector: After by the fune	atic	2 ☐ Accident investiga	ition	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		☐Yes 2☐No			
r Atte er de recto	ij	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number	or Rural Route Number,
talon saft	Certification:		Januari, ot				Only or Town	, Olaro)	
		29a. Certifier ertifying	Physician: To the best xaminer: On the basis of	of my knowledge, de	eath occurred at the	time, date and place	e, and due to the ca	ause(s) and man	ner as stated.
Sol Hin Se	0	one)	and manner sta	ated.					
the Hos nin 24 ho the Fun npletely	ledic		Α .						
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it	Medical	29b. Signature and title of certifier	1) ~~(29c. Licen	se number	7 G	d. Date signed (Month, Day, Year)
To the Hos within 24 hd To the Fun completely	Medic		ALL	L m	29c. Licen	206	29 29	od. Date signed (Month, Day, Year)
310	Medic	29b. Signature and title of certifier	ho completed cause of d	eath (Item 23a) (Typ		206	29 2	Od. Date signed (Month, Day, Year)
10 1	ti i	29b. Signature and title of certifier 30. Note: 11 dress of ers in w	HUA	eath (Item 23a) (Typ		206 0 W	29 25 Au Dur	Od. Date signed (Month, Day, Year) 28/09 20/08
10 1	ate	29b. Signature and title of certifier 30. None of the dress of ters in w 31. Date filed (Month, Day, Year)	ho completed cause of d	eath (Item 23a) (Typerar's Signature		206 0 W	29 25 ALDUI	Od. Date signed (Month, Day, Year) 28/09 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Margaret Mae Tate 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner (In yrs. last birthday) 87 Yrs. 8. Date of Birth (Month, Day, Year) August 20, 1921 Marykand **Funeral** 1 □ M 2 X F 213-18-7275 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural" or items 2000. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland Havre de Grace 1 X Yes 2 No Harford Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America 21078 110 B Bayland Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 💢 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Family Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Mae Shanklin George Howard Maurice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 B Bayland Drive, Havre de Grace, Maryland 21078 Mickey Hebditch (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Angel Hill Cemetery 08-17-2009 Havre de Grace, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Service Li 123 S. Washington St., Havre de Grace, MD 21078 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the dise shock, or heart failur. Approximate Interval Between 4) 10/12 Immediate Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or lighty that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' certificate 2 🗆 No 2UNO 1 ☐ Yes Vital Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) late / / w. Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death † ☑ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation •• Hospital or Att.
•• hours after death.
•• Director; AF 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Uir ary 8/13/09

Registrar

State

HOG K

evolution St- +IDG MD21078.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Millians Hon

32. Fegistrar's Signature

amnidu

31. Date filed (Month Program)

		-	For Stete Registrar	State of Marylar	-		ent of He ate of E		Mer		iene eg. No.	UUS	3 100 J			
Phys		n	1. Decedent's Name (First, Middle, Las Stella	Lucille		Va	lenti	ne	-	Date of Deat Month	Day	Year 2009	3. Time of Death 10:20 A			
	edica mine	_	4a. Facility Name (If not institution, give					Location of Dea		peembe	4c. County of Death					
			Coffman Nursing H	ome	H	agerst	own			1	Washing	ton				
Fune	ral		Social Security Number 6. Security Number		last birthday)	If Un	der 1 Year	If Under 24 Hr Hours Mir	1.	Date of Birth Month, Day,	Year)	Co	nplace (State or Foreign			
Direct	tor		220-10-1445	□ ^{M 2} F 97	Yrs.	World	Days	110010	Au	g. 7,	191:	2 Vir	gínia			
pus A	ş:	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits			
faryli sho		5			•								11∑Yes 2 No			
the A		ect	MD Washing 10e. Street and Number	ton	Hagerst	1	Zip Code			1	On Citiz	en of What Co				
with						101.	21742			,			y .			
ha 23		era	1304 Pennsylvani	a Ave. 12. Was Decedent Ever in U	.S. 13.	Was De		spanic Origin? (Specify	Yes or No-	_	U.S.A. 4. Race - Ame	ncan Indian,			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importments if Itam 27 a marked other than "natural", or Itama 23e or 28e-1 show any injury or other traumatic event. The Medice East if et must be notified at		by Funeral Director	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			pecify Cubar 2 X No	spanic Origin? (n, Mexican, Pue Specify:	rto Rica	ın, etc.)	5	e, etc. ite				
2 hou ature		ed	15. Decedent's Ed	ucation	16a. Dece	dent's U	sual Occupa	tion			16b. Kin	d of Business/	ndustry			
hin 7		Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of DO NO	work done d Tuse retired)	uring most of w	orking							
d wit		0.0	6					Do	mestic							
al Hy Jothy		Be	17. Father's Name (First, Middle, Last) 18. Mother's Name								Maiden S	Sumame)				
Ment Barkac		0	William Henry Bush Amanda Jane Life													
2 sh and lam		d	a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21ores Huffer/Daughter 19700 Huffer Lane, Boonsboro, MD 21713													
and ealth m 27		- 1	Delores Huffer/Dau		1970	0 H1	iffer	Lane, B				21713				
rmit. Pages 1 ar partment of Hea portent: If Itam			20a. Method of Disposition 1 → Burial 2 → Cremation 3 →	Removal from State	Place of Dispo cometery, crer	natory o	vame of or other place	9)	Date		20c. Loc	ation - City or	Iown, State			
tmen tent:			* 4 □ Donation 5 □ Other (Specify	2.0.	st Have			*		009		erstown				
Depar Impor	once		21. Signature of Funeral Service Licens S. Mulk S	5° ,			and Addres Pennsy	s of Facility] ylvania				neral (town, M	-			
Pnysicia	an i		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lication that caused the deat one cause on each line.	h. Do not ent	er the m	nade of dying	, such as cardi	ac or re	spiratory arre	est,		Approximate Interval Between Onset and Death			
/Medic	al.		resulting in death) Due to (or as a consequence of):													
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D #		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
ecute and -tran		Хаш	resulting in death) Last Due to (or as a consequence of):													
be ex				Due to (or as a conseq	derice or,											
ficate be executed physician and sthe burial-transit	:	dica	•	d												
			IF FEMALE:	23c. If yes, outcome of pregna	ancy						2.	Old Date of delivery				
The law requires that the death certification is the second of the attending age 2 should be detached for use a		Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3		pregnancy (specify)				23d. Date of delivery Month Day Y					
that that ned by deta	i		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlyin	g cause give	n in Part I.		23e. Did tob	oacco us	se contribute to	the cause of death?			
puires n sign		d by								1 🗆 Ye	es 2 □]No 3□Pr	obably 4 Scinknown			
w rec beel shou		Completed								24a. Wasa	n	24b. Were au	topsy findings available			
he la e has		E								autops	ned?	prior to death?	completion of cause of			
in: T		ပိ	25. Was case referred to medical					26. Place of De	ooth (C	1 Yes 2	1	1 ☐ Yes	2 No			
/sicie s cert		0	examiner?	Hospital: 1 Inpatient 2	ER/Outpatien	t 3[DOA Othe	r				☐Other (Spec	ufu)			
y Phy er this		_	27. Manner of Death	28a. Date of Injury	28b. Time of		28c. Injury Work			Describe ho			114)			
ndin ath. r: Aft		atio	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	М		? ′es 2 □ No		. ,						
Hospital or Attending Physician: The law requires t 44 hours after death. Fransrel Director: After this certificate has been signe riely filled in by the funeral director, page 2 should be e		Certification:	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a City or Town, Sta									Number or Ru	ral Route Number,			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funarel Director: After this certificate has completely filled in by the tuneral director, page 2.		edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurr vestigat	ed at the tim ion, in my op	e, date and place inion, death occ	ce, and curred a	due to the ca t the time, da	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)			
To the within 2 To tha complet		Ze -	29b. Signature and title of certifier				29c. License	number		2	9d. Date	signed (Montl	n, Day, Year)			
⊢⊀⊢ŏ							D.C	321		0	9-	16-2	009			
			30. Name and address of person who c	ompleted cause of death (Item	23a) (Type	Print)	73	-361			- 1	, 0	/			
			Muhmmad Waseem MD				preto	an Mh	217	7 4 በ						
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	istra		CED DO 98	00 A	1 1	-										

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Funeral Director: After completely filled in by the funeral

Baltimore, Maryland 21215-0036

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

one)

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Learnifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D66930 9-21-09

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENNSYLUANIA AVE HABLESTOWN MD 32. Registrar's Signature

State Registrar

Medical

31. Date filed (Month, Day, Year)

To t

		1	For State Registrar	Sta	te of M	laryland	d / Depa <i>Cer</i>	rtment o	Health	n and M th		Reg. No.	(009	31852
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//	Medica amine	1	a. Facility Name (If not institution Frederick	, give street a	nd numbe	r)	ıl		reder	ick			County of Death Freder	
Fun			032-38. 0652	6. Sex 1 ☐ M 2		Age (In yrs. la	Vre	If Under 1 Ye Months Da		rs Min.	8. Date of Birl (Month, Da ugust	h y, <i>Year)</i> L8 <u> </u>	9. Birth Cou 946 Fra	
Dire		l	Usual Residence of Decedent 10a. State 10b. County				, Town or Lo	cation						10d. Inside City Limits
ne Maryl 8a-f sho	offlied #		aryland Freder	ick		Monro	ovia	10f. Zip Coo	le		T	10g. Citiz	zen of What Cou	1 □ Yes 2√ No ntry?
with th	Garage Character		10e. Street and Number	m	_			21770			1	ISA		
I all ylathin Z IZ (2)-0000 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examination must be notified at	arringr mus	<u> </u>	12106 Ashcroft 11. Marital Status 1 Never Married AMMari				ecify Yes or No Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White					
in 72 hours	Medical Ex	Completed b	3 ☐ Widowed 4 ☐ Divorced 15. Deceden (Specify only highe) Elementary/Secondary (0-12)	t's Education st grade comp	ar or Dates oleted)		(Give	dent's Usual O kind of work d DO NOT use re	one during i	most of work	ing	16b. Kii	nd of Business/h	
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2 should be filed within and Mental Hygiene.	matic	2	Samuel Moore 19a. Informant's Name/Relations	hip (Type, Pr	int)		19b. Mail	ng Address (S				er, City o	r Town, State, Z	ip Code)
ING nd 2 si	r trau		Laurence Brooks			and				rrace	Monro	via,	Marylan	id 21770
es tar of Hea	r othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation			20b. F	Place of Disponentery, cre	osition (Name of matory or other	of place)	9/22	Date /2009	20c. Lo	ocation - City or	Town, State
Page ment	ury o	1	4 Donation 5 □ Other (5	Specify)	ai iroiii oid	Pro	videnc	e Metho	dist	Cemete			rovia. N	Maryland Ineral Home
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Box 6 auth certif	for use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1										23d. Date of de Month	livery Day Year
ds, P.(s been signed by the should be detached	ρ	9 ☐ Unknown Part II. Other significant condi	tions contribu	ting to dea	th but not re	sulting in the	underlying cau	se given in	Part I.				o the cause of death? Probably 4 Unknown
Vital Records, siclan: The law requires t	his certificate has been il director, page 2 shoul	Completed					<u> </u>				24a. Wa au pe 1 □ Yes	topsy rformed?	prior to	utopsy findings available completion of cause of
clan:	ertifica ctor, p	Be C	25. Was case referred to medic examiner?		tal				Other:		ath (Check onl		a = 01 (0)	
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Division of To the Hospital or Attending Phys within 24 hours after death.	To the Funeral Director : After th completely filled in by the funeral	rtificat	3 ☐ Suicide 6 ☐ Coul	d not be rmined 2	8e. Place o buildin	of Injury - At I g, etc. <i>(Spec</i>	home, farm,	street, factory,	office		28f. Location City or 1	Street a	and Number or F ite)	Rural Route Number,
Hospital 4 hours a	Funeral L	Medical Ce	29a. Certifier 1 Certific (Check only one)	al Examiner:	n: To the lo	isis of exami	nowledge, de nation and/o	eath occurred a r investigation,	t the time, on my opinion	date and place on, death occ	ce, and due to to to the time	he cause ne, date a	(s) and manner and place, and de	as stated. ue to the cause(s)
o the vithin 2	Го the хотрlе	Med	29b. Signature and title of certi		and maill	-, 5.0.00		29c.	License nu				Date signed (Mor	
F \$	- 0		1 Jul 2						-	1951		1	- 21 -	
\	14		30. Name and address of personal BTE A	KAZN	11, 44	2 8	314 -		touse	- Ave	Free	Eru	ck. M	n 21701
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCtober ARMSTEAD 17 39 M 2009 ARUE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death The Johns Hopkins Hospital **Baltimore City** s last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In 1 M 2 F -993 Usual Residence of Decedent 10b. Coun Inside City Limits 1 Yes 2 □ No more 10a. Citizen of What Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 2 No 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) egodary (0-12) College (1-4 or 5+) s Name (First, Middle, Last) 19a Informant's Name/Relatio City or Town, State, Zin Code utaw md Method of Disposition Place of D Burial 2 ☐ Cremation Donation 5 - Other (Specify) of Funeral Service Ligenses

Approximate Interval Between Onset and Death

Month

1 Yes

29d. Date signed (Month. Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

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Important: If item 27 is any injury or other trai once.

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Funeral Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

physician and is the burial-tran

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page 2

certificate

after death.

Director: After this

completely filled in by the funeral

Medical

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

POXIA sulting in death) distress Syndion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Other: 1X Inpatient ဂ္ 2 ER/Outpatient 3 DOA 4 Nursing Home 6 Other (Specify) 5 Residence . Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Time of 28d. Describe how injury occurred Certification: 1X Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 □ No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State)

sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ure. List only one cause on each line.

P Hospital of 24 hours a Funeral D within 2

State Registra

Andrew 700. 31. Date filed (Month, Day, Year)

06

29b. Signature and Itle of certifier

29a. Certifier

(check only

t 1. Enter the diseas ock, or hear failure.

diate Cause (Final

ease or condition



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES DOO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legit State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCT. 200 9 Virginia Carol Anderson 1822p 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HArford Upper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Dec. 28, 1945 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 M 2 F MD 212-44-1952 63 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Baltimore 1 ☐ Yes 2 XNo Essex 10f. Zip Code 10a. Citizen of What Country? 10e Street and Number 719½ Myrth Avenue 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4th Elementary/Secondary (0-12) VA Hospital Coordinator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mollie V. Taylor Howard F. Doner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 829 Dorsey Avenue Baltimore MD 21221 Joseph Heming 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 10/6/09 Baltimore MD 4 □ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Fureral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final encephalopathy HNOXIL disease or condition resulting in death) Due to (or as a consequence of): Cardiac arres Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) nancy 23d. Date of delivery 3 Ectopic pregnancy tal death Month Year death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? sulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

Physician /Medical Examiner

Physician

/Medical

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od other than "natural", or items 23a or 28a-f show event, tra Modical Examinar πust be notified at

Department of Health and Mental Hygis Important; if item 27 Is marked other any injury or other traumatic event, it once.

Pages 1

death with the Maryland

physician and s the burial-transit attending pl ed by the a signed t After this certificate has been s funeral director, page 2 should

Examiner Physician/Medical þ Completed Certification: To

F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown
art II. Other significant condition	ns contributing to death but not re

				24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No			
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examiner?	lospital: 1 Inpatient 2 1	ER/Outpatient 3 ☐ [ome 5 ☐ Residence 6	ne 5 Residence 6 Other (Specify)				
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	28f. Location (Street and City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a Certifier 1 Certifying Phys	sician: To the best of my know	wledge, death occurre	ed at the time, date and place	e, and due to the cause(s)	and manner as stated.			

(Check only one)

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and fittle of eartifie

29c. License number D63420 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pper Chesapeake Dr. Bel Aig

State Registrar

Medical

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

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09-07679 Darius Anderson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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/Medica	al		failure. List only one cause mmediate Cause (Final disease	a. Gun	shot Wo	ound To Th										Death	
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_		3	30. Name and address of person Zabiullah Ali, M.D.			se of death (Ite		nn Stre	et, Bal	timore,	MD 212	01					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Las 2. Date of Death 3. Time of Death Year 6.02 PM **Physician** 200 /Medical 4c. County of Death If not inclination, go Town, or Location of Death Examiner JAMAKILAN If Under 1 Year 5. Social Security Number Sex 1 M 2 □ F **Funeral** Months Days Hours -60-7488 Director Usual Residence of Decedent death with the Maryland Inside City Limits City Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1XYes 2 □ No Director no re 10f. Zip Code 10g. Citizen of What Count 10e. Street and Number Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Decements of soul occupation (Give kind of work done during most of working jie. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. is marked other (First Middle, Maiden Surname) Be Pages 1 and 2 should be ည 19b. Mailing Address (Street and 19a. Informant's Name/Relationship Ma permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau QDCs. Place of Disposition (Name of 20a. Method of Disposition ☐ Cremation 16715 5 Other (Specify) 22. Name and Address 21. Sonature of F neral Service Licenses fulton 23a. Prit Enter the dis-ck, or heary fallu-lm reciate Cause (final disease or condition resulting in death) Approximate Interval Between Onset and Death sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flure. List only one cause on each line. SEPTIC. **Physician** SHOCK /Medical Due to (or es a consequence of): Examiner ABDOMINAL Sequentially list conditions, if any least it is in made to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? HEP 24a. Was an has autopsy performed? Yes 2 No 2 □ No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural Natural 5 ☐ Pending investigation n 24 hours after death.

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bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ပ္ RESODO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCH RAVEN BLUD, BALTIMORE, M.D. 560 31. Date filed (Month, Day) State Registrar

DHMH 17 Rev 1/2001

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RODNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day October 1 200^{Year} Mary Price Bishop 1:15 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Pickersgill Retirement Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Bay, Year) 18 1 □ M 2 🗓 F Months Days Hours Min. Mary Land Director 212-03-1066 91 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 - Yes 2 X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 615 Chestnut Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 🎇 No Specify: Specify: White 3√ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 7 hand Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Wesley Price Frances Marian Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health ai : If item 27 is John Bishop, Son 5945 Jumpers Court Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 al Department of H Important: If iter any Injury or oth Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc.: 10/02/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee Name and Address Stacilly of Maryland, Inc. 99 Frederick Road Baltimore, Maryland Thomas Thomas 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ement 14 MICP disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has 1 Tes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PNo ည ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funer 1 Natural
2 Accident 5 Pending 1 Yes Investigation
6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21208

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month TORER **Physician** 3. Year 29 9:30F M HARALD ALBERT BURGARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Joseph Medical Saint Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**X** M 2□ F 219-14-2993 84 Oct 13, Germany Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Carroll County Sykesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6311 Oakland Mills Road 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2□No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Drug Elementary/Secondary (0-12) College (1-4or 5+) Production Company Pharmaceutical Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert A. Burgard Louisa 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc A. Burgard (Son) 2101 Haverbrook Drive, Fallston, Maryland 21047 permit. Pages 1 a Department of He Important: If item any injury or oth once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 10/8/2009 4 ☐ Donation 5 ☐ Other (Specify Baltimore, Maryland 21. Signature & Enteral Service Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland Martin D. Lawson Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LYMPHOMA YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS ANEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 □ Yes investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

ILIA CEBALLOS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

7601

Registrar's Signature

29c. License number

DRIVE,

D25886

TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND 21204

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 000 Blount A . John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b._City, Town, or Location of Death **Examiner** N/A BALTIMORE AGNES HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Days XXM 2□ F MD 12 4 1947 216-50-2580 61 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, The Medical Examinar must be neuthed at 1XX es 2 □ No Baltimore N/A Director MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21229 Avenue Apt 3

12. Was Decedent Ever in U.S.
Armed Forces? Funeral 820 S. 11. Marital Status Caton 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔣 No If Yes, Give Year or Dates: 1 Never Married XXMarried 1 ☐ Yes 2 ☐ No Black Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Porter N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elsie Grant Blount Joseph မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 820 S. Caton Avenue Apt. 3H Baltimore, MD 19a. Informant's Name/Relationship (Type. Print) Shelia B. Blount-wife other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pages Department o Important: If i any injury or once. Greenmount Crematory10/8/09 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Baltimore, MDE21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL 5 HOURS INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transi Due to (or as a consequence of): the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown PROSTATE CANCER 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? HEART FAILURE page perform 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be Vital Records. Attending Physician: Hospital or

should be filed within 72 hours after death with the Maryland

of Health and Mental Hygiene. Item 27 is marked other than

Pages 1 and 2

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physician

Maryland 21215-0036

Baltimore,

Japital or 4 hours after dea. ral Director; A within 24 hours a

To the Funeral I

completely filled

State Registrar

Medical

4 Homicide

(Check only one)

29a. Certifier

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE. BALTIMORE MD

31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 30, 2009 **Physician** 8:00 BERNARD CONRAD BECKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Hospice @ GBMC | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Dec. 24, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1914 Maryland 94 215-03-0369 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantiant, untowardiffed at 1 ☐ Yes 2 XNo Director Maryland Harford Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 21087 8140 Bradshaw Road Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Stationary Engineer 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles William Becker Julia Elizabeth Meid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important: If item 27 is any injury or other trau Irene Heller / daughter 2519 Burgundy Drive, Fallston, MD 21047 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel UMC Cemetery 10/3/09 Joppa, MD 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses Kathleen 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF Complications Dementea Alzhamus **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner executed burial-transit and Due to (or as a consequence of): attending physician for use as the burial Box 68760. law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 □Yes 2 □No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 XNo 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy or Attending Physician; The certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐No : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles Utranucs W 82. Registrar's Signature filed (Month, Day,

DHMH 17 Rev 1/200

State

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	Examir Funeral Director	er	4a. Facility Name (If not institution, gives 15 Social Security Number 6. Social Security Number 171-36-4872 Usual Residence of Decedent	ROOK WH	last birthday)	If Under 1	Year If Under 24 Hrs Days Hours Min.	2	4c. County of C	Death ARC Birthplace (State or Foreign Country) EN (VSY/VAII)
	Maryland f show	or	10a. State 10b. County	10c. Ci	ty, Town or Lo		CEL			10d. Inside City Limits 1 ▼Yes 2 □ No
	with the 7 3a or 28a-	Funeral Director	10e. Street and Number 8 925 PEM	RPCAL II)H\	10f. Zip C			0g. Citizen of Wha	at Country?
036	filed within 72 hours after death with the Maryland Hygiene. the then "naturel", or items 23s or 28s-f show the the Medical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Amed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	1		nt of Hispanic Origin? (S y Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
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Maryland	e d is &	To Be C	17. Father's Name (First, Middle, Last ARTHUR	BAKER				me (First, Middle,	Maiden Sumame) CMANL	V
	nd 2 s lith ar 27 is r trau		19a. Informant's Name/Relationship (Type, Print) YF-DAUPLITER	of a		Street and Number or Ri	12772	-	nte, Zip Code) D- 20 72 3
more,	Page ent o nt: if ry or		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State Mt	Place of Dispo	cemet	of Brolace) 10/2	1 115.1 1	20c. Location - Cit Lansdowne	THE LAND
Balti	permit. Page Department o Important: if any injury or once.		21. Signature of Euperal Service Lice		1 22	. Name and	Address of Facility			MD. 20794
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,	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. hypean	uence of):)		·		years
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	quires that n signed b uld be deta	by	Part II. Other significant conditions (contributing to death but not res	sulting in the ur	nderlying cau	ise given in Part I.			ite to the cause of death? Probably 4 □Unknown
Division of Vital Records,	iiclan: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed						24a. Whas a autopoperfor 1 🗆 Yes	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
T VIE	nysiciar nis certif directo	To Be	25. Was case referred to medical examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA	Other	ath (Check only or dome 5 Resid	ne) ence 6 ☐Other((Specify)
o Lo	ding Pt h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
DIVISI	To the Hospital or Attending Physician: within 24 hours stater death within 24 hours stater death completely filled in by the funeral director; completely filled in by the funeral director;	Certification:	2 Accident Investigatio 3 Suicide 6 Could not be determined	e on Olean of Laine, At h	ome, farm, stro fy)			28f. Location (S City or Tow		or Rural Route Number,
	Hospi 24 hou Funer etely fill	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my kno ninar: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at restigation, in	the time, date and place n my opinion, death occu	e, and due to the durred at the time, o	ause(s) and manne late and place, and	er as stated. due to the cause(s)
1	To the within To the comple	Me	29b. Signature and title of certifler	man, ms			License number	ż	9d. Date signed (A 9-30-0	
1	21		30 Mathe and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	JTHICUM	MD o		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Jan	S				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 09-36 A M 4a. Facility Name (If not institution bive street and number) OCTOBER 2009 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Colum Houa olumbi Social Security Number If Under 1 Year | If Under Months | Days | Hours Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 🕶 F Director 214-52-7403 3/5/47 62 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show 1 Pres 2 □ No Director MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Wicklow Road USA 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ HO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □No Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Completed by Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry injury or other traumatic event, the Predical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Health Care Home Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should ဂ္ Cecil Jones Mary Whyte 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mr. Shelton L. Baldwin, Sr. 720 Wicklow Road Baltimore, Marvland 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Baltimore Crematory | 10/3/09 | Daltimore, 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licersee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER ECAL Physician FEW M. NTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day Month Year 5 Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by CORUNARY ARTERY DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Funeral Director: After th completely filled in by the funeral within 24 hours a

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO D0062634 OCTOBILE 2, Zoig 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA 21044 MATEEN AWAN 10802 HICKORY RIDGE RD

State Registrar 31. Date filed (Month, Day, Year) UCT 0 6 2009 32. Registrar's Signatur

and manner stated.

		For State Registrar	ricas	State o	f Marylan	d / Depa		f Health	and Mo	ental Hy		005	11863
		Hegistrar Decedent's Name (F	First, Middle, I	Last)						2. Date of De	ath		3. Time of Death
Physicia		Charles	A. Br	eitenbac	.h					Month Septem	ber 2	Year 29, 200	9 7:38 PM M
/Medic Examin		4a. Facility Name (If no					4b. City, Town	n, or Location				County of Dea	
7		Anne Ar	undel	Medical	Center		Annap				Aı	nne Aru	
Funeral Director		5. Social Security Num 214-18-		.Sex 1 ☑ M 2 □ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Ye Months Day		Min	8. Date of Bir $(Month, Data)$	av. Year)	C	thplace <i>(State or Foreign</i> ou <i>ntry)</i> ryland
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items 2	nera	11. Marital Status		12. Was Dec	edent Ever in U.	.S. 13.	Was Decedent (If Yes, specify C		rigin? (Spe	cify Yes or No			
af P	by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐	-	If Voc Gi	2 🗌 No		ir Yes, specify C 1 □ Yes 2 🌠 i			ricari, etc.)		Black, Whit Specify: wh	
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s 1 ar f Hea item other		20a. Method of Dispos	ition		20b. F	Place of Dispo	osition (Name of	place)	Da	ate	20c. Lo	cation - City or	Town, State
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagnos.		1 ☐ Burial 2 ☐ C 4 ☑ Donation 5	Other (Sign	cify)	State					<u>.</u>			
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⊷/Medical Examiner		resulting in death)	1	Due to	(or as a conseq	uence of):	= 00	CULA	c				
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death e atte d for u	Physician/Med	in the past 12 mg	onths?	4 ☐ Preg	birth 2□Feta nant at time of o		☐ Ectopic pregn ☐ Other <i>(sp</i> ec <i>if</i>)					Month	Day Year
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or Atterde after de Directo	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	28e. Place	of Injury - At he ing, etc. <i>(Speci</i>	ome, farm, st	reet, factory, offi	се	2	8f. Location City or To	(Street and wn, State)	d Number or F	Ru <i>ral R</i> oute Number,
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the		(Check only 2L	Certifying Medical Ex	Physician: To the taminer: On the t	pasis of examina	owledge, dea ation and/or in	th occurred at the	ne time, date a	and place, a eath occurre	and due to the	e cause(s)	and manner a	as stated. ue to the cause(s)
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Registra	ar	OC!	46 29	09 Cha	m p	1/80							

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Clarence 2009 Burns, 2:05 Medical Oct Α 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7827 Kentley Road Dunda1k Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days 1 12 M 2 D F Hours Director Yrs. 218-42-4991 66 Dec. 8,1942 Marvĺand Usual Residence of Decedent 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Baltimore Dundalk 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7827 Kentley Road 21222 United States filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 9 1 Never Married 2 Married Completed by 1 XXYes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Fire Department Fireman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked of ည and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Clarence B. Burns, Sr. Elizabeth Clark of Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carolyn M. Burns (Wife) 7827 Kentley Road Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 10/7/2009 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Wice Ave. Dundalk, Maryland art 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rart 1. Enter the disease, o complications that caused shock, or heart failure. Let only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner 14 LIGAUNT MELANNIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autonsy 1 Tyes 2 🗌 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Describe how injury occurred 5 Pending 1 Yes 2 No Accident Suicide Accident

Suicide

Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State 29a. Certifier

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital**

Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10× e of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8&19a, perFH, G896, 10/6/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER 2009 **Physician** 8:15 P DANIEL BERNSTEIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner OWINGS MILLS
If Under 1 Year | If Under 24 Hrs. BAL I IMURE

8. Date of Birttl2/30/19199. Birthplace (State or Foreign (Month, Day, Year)

12/20/1919 MD BALTIMORE ATRIUM COURT ASSISTED LIVING 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 89 Yrs 212-07-6220 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any Injury or other traumatic event, Ihe Medical Examinat must be notified at 1 ☐ Yes 2 No Director OWINGS MILLS BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 4730 ATRIUM COURT, #170 21117 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **NEWSPAPER** SALESMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES BERNSTEIN HELEN ပ 119a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRWIN S. BERNSTEIN/SON 8805 SELINA RD., RANDALLSTOWN, MD 21133 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) BETH TFILOH CONGREGATION BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) scular - Dementi **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 ☐ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 2 🗌 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Livia 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral (28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 3/ D47683 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 25

Millo

BET 0 6 2009

31 Date filed (Month, Day, Year)

Street

Restospon

21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2, 2009 Year 6:30 P M Katharine H. Buxton 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 1 M 2 March Pay 9 T 914 Mary Tand 220-16-9121 95 Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location MD Baltimore Parkville 1 □Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA rm # 305 21234 8834 Walther Blvd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3℃Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Goucher College Asst. Registar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Hook John Seng Held 19a. Informant's Name/Relationship (Type. Print)

John Buxton / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2608 Proctor Lane Baltimore, Mayland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/6/2009 Baltimore, Maryland Loudon Park Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed by

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Funeral

Director

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Department of Heal Important: If item 2 any Injury or other

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and

use as the After this funeral

30. Name and address of person when

31. Date filed (Month, Day, Year)

nichealle G. Harrison

QCT 0 6 2009

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

Medical Certification: To Be Completed by Physician/Medical

or Attending Physician: The

State Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ √0 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Year
	contributing to death but not resulting in the underlying cause given in Part I. HTN , Pneumona	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 Yes 2 No No No No No No No
25. Was case referred to medical	26. Place of Deaf	th (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Wursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury N 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) Certifying P 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)

29c. License number

R171944

8500 walther Blvd, Parkville, MD 21234

29d. Date signed (Month, Day, Year)

CRAPI MISN

o completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

CRUP MIST

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 2009 В. 10:00 PM Marv Beere 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 8810 Walther Blvd Apt #1205 Parkville Baltimore 8. Date of Birth (Month, Day, Year)
June 10.1920 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours Min. 1 □ M 2 🖾 F Wisconsin 217-18-6188 89 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County MD Parkville Baltimore 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8810 Walther Blvd Apt # 1205 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Black, White, etc. ∐Yes 21€No 1 ☐ Never Married 2 ☐ Married Specify: Whi<u>te</u> 1 ☐ Yes 2√CXNo If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Brough Margaret Grant 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Keyes / Daughter 1801 Blakefield Circle Lutherville, MD 21093 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp 10/5/09 Towson, Maryland 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Adenocarcinoma disease or condition resulting in death) Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ENo

Physician /Medical Examiner

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within 24 hours a

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Certification: To

Medical

certificate be executed

P.O. Box 68760

Division of Vital Records,

permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau

Physician

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Examiner

Funeral

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Eventher must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter

Saltimore, Maryland 21215-0036

Examiner use as the burial-transi sate has been signed by the attending physician page 2 should be detached for use as the burial

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

25. Was case referred to medical 1 □ Yes 2 **X**No

29b. Signature and title of certifier

OCT 06

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify)

27. Manner of Death 1 Natural 2 ☐ Accident 3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

October 5

Monies 31. Date filed (Month, Day, Year)

8500 2Uc 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 20:30 PM ROSLYN 2009 **BERNS** 09 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner City Baltanoee Hospital ltimore 8. Date of Birth (Month, Day, Year) 05-19-1914 Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Months Days Hours 136-05-0809 95 Director NJ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Experiment using the notified at Director MD 1 □ Yes 2 💢 No BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTTS LEVEL USA 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No þ Specify Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KALMAN WEINBAUM ပ **ESTHER** UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or and PETER BERNS/SON 2410 WEST ROGERS AVENUE, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GARDEN 10-05-2009 ONLEY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROTHERS, 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) P.O. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Completed Heart 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s Jas autopsy performed cate Division of Vital 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) R No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as states.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 06 2009

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** XUL /Medical 4a. Fecility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE 2906 DUNBRIN ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/9/1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F Yrs OHIO 80 Director 217-22-5853 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show 10a. State itam 27 is marked other than "natural", or Itams 23a or 28a-f shov othar traumatic avant, the Madical Exprenent must be notified at 1 ☐ Yes 2 No MD. BALTIMORE PARKVILLE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8814 SPRING ROAD 21234 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 2 should be filed within 72 hours after or and Mental Hygiene.

Is marked other than "natural", or Ital 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH 0 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BESSIE EARL M. SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If itam 27 Is JAMES T. BAUGHMAN/SON 8814 SPRING ROAD, PARKVILLE, MD. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: If any injury or once. BALTIMORE, MARYLAND GARDENS OF FAITH 10/6/09 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. BALTIMORE. MARYLAND 6224 EASTERN AVE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine signed by the attending physician and d be detached for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 TYes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 🔲 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at Work? Certification: Attanding 1 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No l or Attand after death Diractor: the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of c 30. Name and add npleted cause of death (Item 23a) (Type, Print) MAIN Sheek BOB 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician OCTOBER 2009 ANNA CATHERINE EBERLY COTTERINO 7:18 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death CORSICA HILLS CENTER CENTREVILLE QUEEN ANNE S

9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 87 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jun 2, 1922 **Funeral** Days Hours Min. 1 □ M 2 🛣 F Mary land 218-12-5345 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar, ust by nofffled at 1 ☐Yes 2 No Director Maryland Queen Anne County Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 712 Murphy Road 21617 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Patrick Eberly Gabrella Pearl Pressman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) George F. Sweitzer 712 Muurphy Road, Centreville, MD 21617 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1∑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

21. Signature Finance Service Conservation

Martin D. Lawson Dulaney Valley Mem Grdns 10/9/09 Timonium, Maryland MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) movascular occident **Physician** north /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, lettering to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for I Month Day Year 5 Other (specify) 1 ☐ Yes 2 No detached signed by the 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an certificate has autopsy performed? res 2 No 1 □ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred . After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the within To the 29b. Signature and title of certification 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 8:31AM CRESSMAN LUTITER PAUL SED 30 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner many HOWARD COUNTY GUNGRAZ HUSPITAL awns1A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 579-58-8736 Oct 25, 1943 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Howard **Ellicott City** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3008 Autumn Branch Ln 21042 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>^</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို Roy Cressman Amelia Baer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Cressman 3008 Autumn Branch Ln. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 02, 2009 Glen Burnie, MD Atlantic Crematory, LLC 21. Signature of Funeral Softice 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 e, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or neart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3DAYS PNEUMO CO CLAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMMIA 7 DANYS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for se a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ACUTE REMAN RAILURE N Tes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed METARNIC MUDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ ■ 24a. Was an Phimmary UMANIC OBSTRUCTIVE DISGASE 1□ Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: ို 1 mpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death. I Director: / d in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral D Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OM MOTINAPIN. O

29b. Signature and title of certifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

1) 36974

10724 LITTLE PATUXENT PARKWAY

29d. Date signed (Month, Day, Year)

2009

Corumsia mo 2544

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Er 29 2009 :29 YM **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Director Jsual Residence of Decedent the Maryland 10d. Inside City Limits or 28a-f show notified at 10a. State 10h. County 10c. City, Town or Location 1X Yes 2 □ No BaltiMore Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 6 ral", or items 23a o Examiner must be Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical dother than " College (1-4 or 5+) Elementary/Secondary (0-12) Haltimore Gasard and Mental Hygiene. event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked James ည traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Baltimore of Health 27 Marylanu item 2 20c 20a. Method of Disposition 20b. Place of Disposition (Name of Date Location City or Town, State Department of Important: If it any injury or o once. 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) crematory 21. Signature Licer see M6155 Maryland 2/2/2 BaIHMUVE Treene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death
9 Unknown 5 Other (specify) 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No Yes 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) funeral (27. Manner of Deat 1 Natural 2 Accident 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day 5 Pending investigation death. 1 Yes 2 □ No filled in by the 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number. determined 4 Homicide City or Town, State)

after death within 24 hours a To the Funeral D Hospital the

Medical completely State

29b. Signature and title of certifier

29c. License number RES-000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who commeted cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year)

29a. Certifier (check only

one)

32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day 2009 Year **Physician** Catherine I. Chetelat 2 Oct. 10:00a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 420 Torner Road Essex 8. Date of Birth (Month, Day Year) 1925 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 219-12-8482 1 ☐ M 2 ☐ MF Director 83 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore Essex Director 1 ☐ Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 420 Torner Road 21221 Funeral filed within 72 hours after death or Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc XYes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 DMGo Specify. White þ Specify. 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Ironmonger Merle Clark ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health ar item 27 ls 420 Torner Road Baltimore MD 21221 William Chetelat /husband 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 10/5/09 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave, Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CAROTOMYOPATHY /Medical Due to (or as a consequence of): Examiner 2003 ATRIAL FIBRILLATION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed HYPERTEWSION burial-tran years and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical MUXDOMA the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ctopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ğ Month 5 Other (specify) P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? After this certificate 2 No 1 ☐Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division To the Hosper, within 24 hours after used. To the Funeral Director: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D41496 MO Saba Siddigi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO MD 21137 9106 philadelphia RD SABAS IDDI 01 32. Registrar's State Registrar

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of I			ene g. No. 200	9 31874
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Maryland 21215-0036	e filed within 72 hours after death with the Maryland ttal Hygjene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 🗶 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 X/es 2 If Yes, Give Year or Dates. 5	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ Xo	an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. white
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Baltimore,	permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even once.		20a. Method of Disposition 1 ☐ Vaurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	Dulaney	Valley N	lemorial	Gardens	Coc. Location - City	m, MD
Bal	permit Depar Impol any in		21. Signature of Funeral Society is en	ile	<u> </u>	2. Name and Addre	ss of Facility Uneral Padonia F	lome of D	ulaney M	alley ₉₃ inc.
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Division of Vital Records, P.O. Box 68'	To the Hospital or Attending Physician: The law requires that the death certifin within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the live Birth of the li	2 Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of Month	delivery Day Year
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	10 x1		30. Name and address of person who Richard O'Malle				Suite 3	311, Tows	son MD	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Month Day Year Clark 3:05 P 200 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Hospital Baltimocc SCLOUIS 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1177k 11♥ M 2 □ F Months Days Hours Min unk Director 216-78-0740 49 Dec 21, 1959 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at Director 1 TYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1941 Ramsay Street 21223 USA Funeral Unk 12. Was Decedent Ever in U.S. Armed Forces?
arried 1 □ Yes 22 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 1 ☐ Yes 21 No 3 Widowed 4 Divorced Specify black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 27 is marked of traumatic ever ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bon Secours Hospital 2000 W. Baltimore Street Baltimore, r other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5KlOther (Specify) in state State Anatomy Board 655 W. Baltimore Street arrector. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate 15 Final disease or conditions. Approximate Interval Between Onset and Death Physician hypotension disease or condition resulting in death) Lyours /Medical Due to (or as a consequence of): Examiner herni Drain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-tran P.O. Box 68760, Physician/Medical IDS IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director; Af
completely filled in by the fur investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State Registrar Dell

DHMH 17 Rev 1/2001

Barks

2000 W.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Simnons

JUL U 6 2009

31. Date filed (Month, Day, Year)

29c. License number

timose St.

66108

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Carleton Cheatham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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edical Exami	ner	Carleton Cheatham		Month D September 2		2020 hrs
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Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.	7	Foreign	· - ` -
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21215-0036 ould be filed within 7 I Mental Hygiene. marked other than ic event, the Medica	To E		Mabel Ma Address (Street and Number or F		er, City or Town, State,	Zip Code)
5, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene, marked other than "natural", or items 23a or 28a-fish traumatic event, the Medical Examiner must be notified at once		Michelle Cheatham/daughter 7 B	lue Heron Court	Baltimore	e. MD 2122	20
ore, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any ther traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Dispos	ition (Name of cemetery,		20c. Location - City or 1	
Pages ent of unt: 1		1 Burial 2 Cremation 3 Removal from State 4 Population 5 X Other Specify	los pidoo,			
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Montal Hygier en Important: If tiem 27 is marked other in july or other traumatic event, the Med		21. Signature of Funutral Service Littonsee 22. N	lame and Address of Facility	1 (55 33	D 1	G
0 82 1 1		Ball Ball	ite Anatomy Board Ltimore, MD 2120	J		
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as cardiac o	r respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
taminer		Immediate cuse (Final disease a. Hypertensive Atherosclerotic Cardi	ovascular Disease			Death
		or condition resulting in death) Due to (or as a consequence of): b.				
	ЭE	if any, leading to immediate Due to (or as a consequence of):				-
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit		events resulting in death) Last Due to (or as a consequence or): d.				
e exec cian ar rial - t	Medical	UNPENDED AMENDED				
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Box 687 he death certific the attending p	Physician	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Ot	her (Specify)			
O. E at the o		Part II. Other significant conditions contributing to death but not resulting in the contributions	Inderlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by all director, page 2 should be detach.	d by			1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
rds requi been hould	Completed			24a. Was an autopsy		opsy findings available ompletion of cause of
eco le law te has ge 2 s	g.			perform 1 Yes 2	ed? death?	•
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Vita ysicia his ce direct	Ö	examiner? 1. ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor	P	esidence 6 🗸 Other:	Scene
ing Ph After t	-	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of I	njury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
ion tendii eath. for: /	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
Division of Vital Records, optal or Attending Physician: The law require users deer death. After this certificate has been si filled in by the funeral director, page 2 should b	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	et, factory, office building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rur	al Route Number, City
Spital spital sours	Certification:	4 Homicide determined (Specify)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Atending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur one) Medical Examiner: On the basis of examination and/or investigate				
To the within To the comp	Medical	2 Medical Examiner: On the basis of examination and/or investigate and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor.	
	=		O.C.M.E.		September 29, 20	
		30. Name and address of person who completed cause of death (Item 23a)				_
			Penn Street, Baltimore, M	1D 21201		
St	ate	31. Date filed (Month, Day, Year) 62. Registrar's Signature				
Regis	trar	OCT 0 6 2009 Senous S. Jak		-		

		-	For State Registrar	State of	Marylan		artment of H			ene 201	19	91377
П	Physicia	n/	1. Decedent's Name (First, Midd	le, Last)					2. Date of Death Octobe		eero I	3. Time of Death
	Medic	al	Nancy 4a. Facility Name (if not institution	Jar		Davi		Landing of Dooth	Octobe	Τ		7:16a. [™]
-	Examin	er	Union Memo					Location of Death		4c. County of I		
	Funeral Director		5. Social Security Number 212-32-6654	6. Sex 1 M 2 K X	7 4 Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9.	. Birthplace Country)	e (State or Foreign VA
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. Count		10c. Cit	y, Town or Lo	cation				10d.	Inside City Limits
	Maryla 18a-f s atified	Funeral Director	MD I	A/A	Ba	altimo	ore					1 🕶 Yes 2 □ No
	h the had a or 2	al Di	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	it Country?	?
	th wit	ıner		20th Stree			21218			USA		
ပ္	or ite	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Ma	12. Was Decede Armed Force	es?		Nas Decedent of His f Yes, specify Cubar		Rican, etc.)	14. Race - A Black, V	American I White, etc.	
003	urs aft ural",	ted t	3 X Widowed 4 □ Divorce	If Van Cina		Í	Yes 2 🗓 No	Specify:		Specify:	Blac	k
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pu	filed valued all Hyg	Be C	17. Father's Name (First, Middle,					18. Mother's Nam	e (First, Middle, Ma	iden Surname)		
yla	uld be I Ment narke	욘	Frank	Willian	ns			Rebe	ecca		Bea	le
Maryland	2 shorth and the and traum		19a. Informant's Name/Relation Gloria Davi		er		ng Address (Street a E. 20th			-		e) 1218
ē,	1 and of Heal item	_ 1	20a. Method of Disposition		20b. P	Place of Dispo	sition (Name of		Date 2	0c. Location - Cit	ty or Town,	, State
imo	Page nent c ant: If ury or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other		tate K3	ing" Me	emorial ^{lace}	%k 10/1	.0/09	Randal	lsto	wn MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee B. K	he K		Name and Addres	1.174	RCH FUN	ERAL HO	OME- re,	EAST MD 21202
			23a. Part 1. Enter the disease, of shock, or heart fall e. List	or complications that car	use the death						Ap	oproximate terval Between
	Physician/		Immediate Cause (Final disease or condition	_ a		CA	D					nset and Death
7	Medical Examiner		resulting in death)	Due to (or	r as a consequ	uence of):	LVD.					
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	r as a consequ	1	- 0 +3				+	
B	uted Id ansit	Examiner	Cause (Disease or iinjury that initiated events	G								
	ath certificate be executed attending physician and for use as the burial-transit	a E	resulting in death) Last	Due to (or	r as a consequ	uence of):						
09/	physic the bi	Physician/Medical		d								
687	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7			23d. Date o	of delivery	
Вох	death e atter	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		ant at time of d		Ectopic pregnancy Other (specify)	У		Month		y Year
0.	es that the decsigned by the signed by the signed by the signed by the signed is the signed in the signed is the signed in the signed is the signed in the signed is the signed in the signed in the signed is the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the signed in the s	Phys	9 Unknown Part II. Other significant condit			ulting in the u	ndorlying on you give	on in Bort I	00 8:11.1			
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Records,	requires been sig	Completed				_			24a. Was an			findings available
ecc	The law cate has	omp							autopsy performe	ed? prior	r to comple th?	etion of cause of
аВ	iician: The certificate rector, pag	Be C	25. Was case referred to medica examiner?				26. Pla	ice of Death (Check	1 Yes 2 k only one)	∠No 1⊔	Yes 2L	140
of Vital	Physician: this certifica ral director, p	은	1 ☐ Yes 2 ☑ No			ER/Outpatier	nt 3 DOA Othe	r: 4 🗌 Nursing Ho	ome 5 Residen	ce 6 🗆 Other (S	Specify)	
n 01	ng fter Ine	Certificate:	27. Manper of Death 1 ✓ Natural 5 ☐ Pend 2 ☐ Accident Inves	ing 28a. Date of (Month,	injury , <i>Day, Year)</i>	28b. Time of injury	28c. Injury work? M 1 🔲	at ? Yes 2 □ No	28d. Describe how	injury occurred		
Division	l or Attendi after death Director: A I in by the fu	artifi	3 Suicide 6 Could	not be 28e. Place of			eet, factory, office		28f. Location (Stre		r Rural Roi	ute Number,
Ω̈́	ital or urs aftural Dir ral Dir lled in				, etc. (Specify				City or Town, S			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the to	Medical	(Check 2 Dedical	9 Physician: To the bes Examiner: On the basis 9 Nurse Practioner: To	of examination	n and/or invest	tigation, in my opinior	n, death occurred at	the time, date and	place, and due to	the cause(s	
	To the within 2 To the comple		29b. Signature and title of certific	<u> </u>		,	29c. License			d. Date signed (M		
	11		Vann 1	N ()			1251	111	1	0/05/	190	
	H		30. Name and address of person	who completed cause	of death (Item	23a) (Type, F	Walth	am h	voods	Road		Suite 204
	Stat		31. Date filed (Month Day Year)	C 2000 32. 100	jistrar's Signat	ture	and d				1	117 21234
	Dogistre			n /tery / #/-	LEKAL	CI. JUST	CALLOS					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4c, perPHYS. G896, 10/6/09, WS
State of Maryland Poepartment of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30^{Day} Sept. 2009 **Physician** 9:00 AM William B. Davis /Medical 4c. County of Death **Baltimore** 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Randa11stown Seasons Hospice | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis | Rangalis 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Country) North **Funeral** . XX M 2□ F 217-07-2674 93 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ∐Yes XX No Director Abbington Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21009 1202 Cotswold Ct. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🏋 No Specify. Black Specify: ģ XXWidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Burner Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth other traumatic even (unknown) Mable Robert Davis ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Owings Mills, MD 21117 344 Kearney Dr. Lillie Henley / Daughter If item 27 or other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial XXCremation 3 ☐ Removal from State permit. Page:
Department o
Important: If
any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/7/09 Baltimore, Maryland 21. Signature of June al Ser ce Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 propose 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Atheroscierotic cardiovascular disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Our to for as a consiquence of Examiner burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical the as t for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ № 9 Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 □No 1 ☐ Yes 25. Was case referre o medical examiner? funeral director, Be 26. Place of Death (Check only one) haspice Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ∐Wo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manyer of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) completely and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 130/09 00057465 1/SKajapahreMI) 30. Name and aggress of person who completed cause of death (Item 23a) (Type, Print) 200 MD. 21136 Reisterstown, S. Rajapakse, MD 25 Main St., Suite 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			1 - State of Maryland / Department	nt of Health and I te <i>of Death</i>		iene _{eg. No.} 2003	31875			
I	Physicia		1. Decedent's Name (First, Middle, Last) Charles S. DeLuca, Jr.		2. Date of Death		3. Time of Death 6:42 p _M			
	Medio Examir		4a. Facility Name (if not institution, give street and number) Stella Maris 4b. City	/, Town, or Location of Death	1	4c. County of Death Baltimore				
	Funeral Director		215-09-9251 1 🔀 M 2 🗆 F 92 Yrs. Months	er 1 Year If Under 24 Hrs, Days Hours Min,	8. Date of Birth Dec 25,	^{9. Bir} 916 Viç	thplace (State or Foreign			
•	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	8424 Charles Valley Court Apt E 2. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Forces? 14. Was Decedent Ever in U.S. 15. Was seen	ip Code 1204 edent of Hispanic Origin? (Sp cify Cuban, Mexican, Puertc	necify Yes or No-	0g. Citizen of What Co	USA rican Indian,			
9 6:42 p.m	ed within 72 hours after of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of the street of th	Be Completed by	1 Never Married 2 Married 1 X Yes 2 No If Yes, Gilve Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 Never Married 2 Married 1 X Yes 2 No If Yes, Gilve No If Yes Year or Dates. 1 10. Decedent's Usu (Give kind of we life. DO NOT us Steel World)	2 🔀 No Specify: ual Occupation ork done during most of work the retired) ker	king	16b. Kind of Business Steel	hite			
4, 2009 Maryland	should be file and Mental I is marked o raumatic eve	To E	Charles S. DeLuca, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	Cather ss (Street and Number or Rur anor Rd. Glen	ral Route Number, (OSE City or Town, State, Zi,	o Code)			
OCTOBËR A	Page 1 and 2 nent of Health ant: If item 27 iry or other ti		Mrs. Patricia Schwartz/ Daughter 11644 M. 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	me of	Date 2	20c. Location - City or Timonium,				
OCT Balti	permit. I Departm Importa any inju		21. Signature of Funeral Service Licensee 22. Name 2	uckdre¶sowsom Fu 050 York Rd.	neral Ho Towson,	me, Inc Md: 21204				
09	by Medical be executed attending physician and for use as the burial-transit	edical Examiner	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the most shock, or heart failure. Listlonly one cause on each line. Immediate Cause (Final disease or condition resulting in death) BLADDER CANCER Due to (or as a consequence of): b. Just to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):	ie or dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death			
. Box 687	ne death certificate r the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	ivery Day Year			
CHARLES DELUCA of Vital Records, P.O.	The law requires that the sate has been signed by page 2 should be detail	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. Were au	the cause of death? robably 4 \sum Unknown ropsy findings available completion of cause of 2 \sum No			
CHARL Division of Vital	the Hospital or Attending Physician: The law requires that the death certificate be execute the Layer death. The Layer as after death. The Layer as after death. The Layer as after this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-trans	To Be	To Be	To Be	Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 D	28c. Injury at work? 1 □ Yes 2 □ No	ome 5 Resider 28d. Describe how	eet and Number or Rui	
ot	To the Hospital or A within 24 hours after To the Funeral Direc completed filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in 29b. Signature and title of certifier 29c. 29b. Signature and title of certifier 29c.	my opinion, death occurred a	t the time, date and ce, and due to the c	place, and due to the	ause(s) and manner stated stated.			
	Sta Registra	te ar		RD. TIMONIUM	1. MD 210	93				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Montb Day Vear **Physician** Julia otember 29,2009 English /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSDIta Damantan Date of Birth (Month, Day, Year) 5-16-1927 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 ₩ F Days Months Hours Min. 217-26-0448 82 Director S.C. Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 1521 Shadyside Road USA 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ English, Julid Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working

life. DO NOT use retired) Housekeeping Fort Howard Hosp 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) vear 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maggie Brown ဠ George W. Sawyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is in any injury or other traun once. Bobby A. English-Son 9709 Southall Road Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sweet Prospect Cem.10/10/09 Winnsboro SC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Per 22. Name and Address of Facility Licensee March East F/H 21202 MD1101 E. North Avenue BALTO, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list ounditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an autopsy 1 ☐Yes 2 **2** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Time of Injury 28c. Injury at Work? 28b 28d. Describe how injury occurred 5 Pending investigation nours after death.
neral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated

State Registrar

0

29b. Signature and title of certifier

na

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

onna

32. Registrar's Signature

D0062735

29d. Date signed (Month, Day, Year)

Loch Raven Boulevard, Baltimore 21739

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HURMOND DETENBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HE2S MITAL CENTER CONTHUEST BALTIMUNE ANDALISCOUN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 21,1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months 1 □XM 2 □ F 236-20-0429 87 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evandre, must be notified at Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 1 and 2 should be filed within 72 hours after death with I of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or items 21207 USA 5522 Windsor Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. 2yrs <u>Engineer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lorraina Gourley Ellis Ervin ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara White / neice RRI Box 72A Burlington WVA 26710 20b. Place of Disposition (Name of Pages 1 Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of the Important; If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 10/9/09 Baltimore MD 4☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee $^{22.\;\text{Name and Address of Facility}}$ 300 Mace Ave. Balto. M Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PARDIONY OPATHY Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Exami Due to (or as a consequence of) attending physician for use as the buria requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, CONGESTIVE HEART FAILURE - PERIPHERAL VASCULA DISEASE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed STATUS BILATERAL ABOVE KNEE AMPUTATION; HYPERTENSIE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 autopsy certificate ATRIAL FIBRI LATTEN (themesoly to perio 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ⊟Yes 2 🖫 No Certification: To this funeral 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Unatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEATHWEST HOSPITAL ORLANDO B. CONTANAN RAND XIISTOWN, MANGLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 OCT 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Ann Ellenburg Physician/ Karen 2009 4:33 P M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Gilchrist Nursing Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Country) 1 □ M 2 🖵 F Director 10.1957 Maryland May 216-72-5329 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d Inside City Limits 10c. City. Town or Location death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Dunda1k Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4024 St. Augustine Lane United States 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Worker Warehousing $G_{\bullet}E_{\bullet}D$ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Alice Duff Edward Harris 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Elmer Lee Ellenburg 4024 St. Augustine Lane Dundalk, MD 21222 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department or Important: If any injury or Hilltop Service Corp. 10/6/2009 Towson, Maryland 4 Donation 5 Other (Specify) . Sign of Funeral Service Li 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair e. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final isease or condition Physician BCOOK-3008 a. 100-50011 cell Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death
Unknown the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive Dulmonory alsease 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?
☐ Yes 2 No After this certificate 1 🗆 Yes 2 🗆 No 25. Was case referred to medical completed filled in by the funeral director, Be | 26. Place of Death (Check only one) Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 8 Other (Specify) +050,00 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending s after death.

Director: Af 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier . License number R145356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) OCT 0 6 2009

32. Registra s Signat

				Pleas	e Type or Prir					-		_egible.	
			For State		State of Ma	aryland / [Departme <i>Certifica</i>			•			
			Registrar 1. Decedent's Name	(Eirot Middle	(act)		Cerunca	ile oi l	Jeath	2. Date of De	Reg. No.		3. Time of Death
	Physicia	an	Cleo D.		Lasij					October	Day	2009	3:00 A M
3	/Medic Examin				give street and number)		4b. Cit	v. Town. or	Location of Death			County of Deat	
	Examin	er			Nursing Home			herv				ltimore	
	Funeral		5. Social Security N		3. Sex 7. Ag	e (In yrs. last bir		er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9. Birti	hplace (State or Foreign untry)
	Director		468-30-3		1 M 2 X F	76	Yrs.	Days	TIOUIS WIII.	Jan. 11	, 19	33	Minn.
	and w		Usual Residence of 10a. State	10b. County		10c. City, Town	n or Location						10d. Inside City Limits
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7	d with giene er tha	Completed	Elementary/Secon	ndary (U-12)	College (1-4or 5	Cle	erk				CSX	Transpo	rtation
3 :	be filed within 72 hours after death with the Maryli tal Hygiene than "natural" or items 23a or 28a-f sho event, the "Modeal Examinatin ust be notified at	Be (17. Father's Name (First, Middle, La	ast)				18. Mother's Nan	ne (First, Middle	, Maiden S	Surname)	
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the "Modeal Exercitor" is ust be notified at	흔	Blanchard	d J. Dak	<u> 11 </u>				Gladys /	A. Sheeh	an		
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3	permit. Pages 1 and 2 should be filed within 75 Department of Health and Mental Hygiens, Important: If Item 27 is marked other than "ns any injury or other traumatic event, in the Medica.		Digitatore or ru	12	10400 x				Funeral	Home.	Inc.		n, MD 21204
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The law requires that the death continues		e Completed	25. Was case referr	ed to medical					26 Place of Dec	auto perfo 1 □ Yes	psy ormed? 2 No	prior to o	completion of cause of
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 19a, b, perFH, 6896, 1079/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 3:00 P KATHY GAIL GILMAN **OCTOBER** 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford 131 Hopkins Road Havre de Grace If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 1 □ M 2 🛣 F 54 July 22, 1955 Maryland 10d. inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Havre de Grace 10g. Citizen of What Country? 10f. Zip Code 21078 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√2 If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 ➡No Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Transportation Administrator | Public Education 18. Mother's Name (First, Middle, Maiden Surname) Lucille (nmn) Leonardi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)

Robert Charles Gilman Jr./Husband
Chuck Gilman / Husband 131 Hopkins Road, Havre de Grace, Maryland 21009 e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) noval thom State Harford Memorial Gdn 10-6-09 Aberdeen, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Melast alle 100 Due to (or as a consequence of): Duri to (or as a consequence of) Due to (or as a consequence of):

23d. Date of delivery

Year

Month

33099 1075709 en Ave, orig MI)

<u>≽</u>

Be Completed

Medical Certification: To

25

31. Date filed (Month, Day, Year)

OCT 06

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director;

9 □ Unknown									
Part II. Other signif	icant conditions of	ontributing to death but not res	sulting in the underly	ing caus	se given in Part I.		/	se contribute to the cause of death?	
						-	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
25. Was case referr	red to medical				26. Place of D	eath (0	Check only one)		
examiner? 1 ☐ Yes 24 ᡚ	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	□ DOA	Other: 4 Nursing	Home	5 XResidence 6	Other (Specify)	
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		. Injury at Work? 1 □Yes 2 □No	280	d. Describe how injury	occurred /	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one)		ysician: To the best of my kn niner: On the basis of examin and manner stated.						and manner as stated. place, and due to the cause(s)	
29b. Signafure and title of certifier					29c. License number 29d. Date signed (Month, Day, Yea			e signed (Month, Day, Year)	

3 Ectopic pregnancy

5 ☐ Other (specify)

If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SVAC

State Registrar

DHMH 17 Rev 1/2001

700

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year Physician/ TOBER 5:50 P CLAIRE BERNADETTE GUTHERIE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center @ GBMC Baltimore Towson 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days New York 1 □ M 2 🛛 F 097-05-8491 Director 93 1916 Mar. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2X No Maryland Baltimore Parkville 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Numbe Completed by Funeral 8810 Walther Blvd. 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 ☐**X**No Yes, Give (215-0036 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Harry (nmn) Ray Catherine (nmn) Doran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Thomas / Daughter 3280 Green Ash Road, <u>Davidsonville, MD 21035</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 X Buril 2 ☐ Cremation 3 ☐ 4 ☐ Doration 日 ☐ Other (Specific Ignatius Cath. Cem. 10-6-09 Forest Hill, Maryland 21. Sign e of Function S McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pold 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ RMOTIO Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day within 24 hours a rer death.

To the Funeral Director. After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an MIMOURY autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 2 40 7,00 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

West

OCT 06 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edwin Joseph Goodwin State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day Y September 26, 2009 1745 hrs **Medical Examiner** Edwin J. Goodwin 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 201 N. Washington St. Apt 1007 **Baltimore** If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** unk oreign Months Days Hours Director 213-34-9558 Country) 1 X M 2 71 Oct 21, 1937 Usual Residence of Decedent 10d. Inside City Limits any 10c. City. Town or Location 10a State 10h County s 23a or 28a-f show e notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23a or 28a-f sho Baltimore Director 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 201 N. Washington Street #1007 21231 USA 12. Was Decedent Ever in U.SINK 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Funeral 11 Marital Status unk must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes Divorced If Yes, Give Year Yes 2X No specify. black. Widowed Specify ⋧ 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ' Baltimore, MD 21215-0036 unk 18.Mother's Name (First, Middle, Maiden Surname) unk 17, Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town State 20a. Method of Disposition crematory or other place) or other Burial 2 X Cremation 3 Removal from State ment o 10/6/09 Baltimore, Md. Bayview Crematory 22. Name and Address of Facilit Connelly uneral ervice Licensee .Home of Baltimore, MD 21201 10 Sollers 51 is a detailed by the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Konald** art I. Enter the disease, or complication Approximate Interval **Physician** Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Imme te Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): ner if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and g UNPENDED AMENDED#20a-c,22perFH,G896,10/19/09,WS ending physician use as the burial Physician/Med Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown q Hinknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 V Unknown Yes 2 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? Yes 2 ✔ No death? this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other₄ examiner? Hospital: 1 DOA ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred fication: 1 1 Natural Yes 2 5 Pending Director: 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 Could not be Suicide or Town, State) determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 28, 2009 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c Per FHs 6896 Mar 97 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** РМ 2, 2009 3:00 Anthony October 0 Gerace /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner #2601 Towson Baltimore 28 Allegheny Ave. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Months Days Hours Director May 26, 1928 Maryland 216-22-3799 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprintment mast be notified at 1 □Yes 2X No Director Md. Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 USA 28 Alleghenv Ave. #2601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XCYes 2 □ No IfYes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ KNo Specify Specify: þ White 3 ♥ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) **Plastics Owner** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Monaco Angelo Gerace ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Allegheny Ave. #2702 Towson, Maryland 21204 Werner/Friend Joseph 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Unit 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Oct.09,2009 Timonium Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) Towson, 21. Signature of Funeral Service Lice Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or shock, or heart failure. Lis plications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Myoundia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VONAVY Chy Sequentially list on diffunc, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 🔲 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 D Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 □Yes 2 1No 2 No al or Attending Physician: 3 safter death.
Il Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 A Residence 6 ☐ Other (Specify) Certification: To 27. Ma r of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760. within 24 hours a

To the Funeral D Hospital

Baltimore, Maryland 21215-0036

Registrar

Medical

29a, Certifier

(Check only one)

arl

29b. Signature and title of certifier

30. Name and address of person who

Day,

29d. Date signed (Month, Day, Year)

and manner stated.

completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 509 South Hammonds Ferry Road Anne Arundel Linthicum If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 12, 1948 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F 219-50-7227 61 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show traumatic event, the Wedical Executiving quantities notified at 1 ☐ Yes 2 ☐NÑo Director MD Anne Arundel Linthicum 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 U.S.A. 509 South Hammonds Ferry Road or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 X Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) International Lending Banking marked other 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) in and 2 should be fill Health and Mental Hem 27 is marked of Robert L. Bowler Carloyn L. Crowell ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 Harbor Drive Annapolis MD 21409 Mrs. Dana Cate/ Daughter Department of Health Important: If Item 27 any Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 5. Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** 34 disease or condition resulting in death) /Medical Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed siclan and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physiclan the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the 1 ☐ Yes 2 ☐ No 9 ☐ Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by .1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ ⊀No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) DEFENSE HIGHWAY ANNAQUISMILIEOI completed cause of death (Item 23a) (Type, Print) ame and address of person w no un 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please	Type or Print in State of Maryla					-		
		For State Registrar	State of Maryla	Reg. No. 2019						
		1. Decedent's Name (First, Middle, Last) 2. Date of Death						Day Year	3. Time of Death	
Physicia /Medic		Elden Reed	Hickman					02 200		
Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea		
		8178 Great Bend				Burnie		Anne An		
Funeral Director		117 M 2 F Months Days Hours Min. (Month, Day					8. Date of Birth (Month, Day, Ye)	Pay, Year) Country)		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be nealfied at once.	tor	10a. State 10b. County MD Anne Ar		City, Town or 1en Bu					10d. Inside City Limits 1 ☐ Yes 2 No	
	Funeral Director	10e. Street and Number 8178 Great Bend	reet and Number 78 Great Bend Road				10g.	10g. Citizen of What Country? U.S.A.		
ns 2;	ıera	11. Marital Status	12. Was Decedent Ever in I	U.S. 1	2106 3. Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	nerican Indian,	
urs after d al", or iten	Completed by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1		If Yes, specify Cub 1 □Yes 2∏ No	oan, Mexican, Puerto Specify:	o Rican, etc.)	Black, Whi	ite, etc. Vhite	
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d 2 sk th and 7 is r traur		19a. Informant's Name/Relationship (ral Route Number, C			
1 and Heat em 2		Mrs. Mitzi M. Hic 20a. Method of Disposition			78 Great sposition (Name of prematory or other pla			n Burnie. c. Location - City o	MD 21061	
ages ant of t: If it		1 ☐ Burial 2 【☐ Cremation 3 ☐	Hemoval from State			1		31 . D .	5 (7)	
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Depi Impo		21. Granature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MI Singleton Funeral & Cremation Services, PA								
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
executed an and rial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
physician ptysician the buria										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1	tal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of d Month	elivery Day Year	
w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrib								
he law req e has beer tge 2 shou					=		24a. Was an autopsy performe	d? prior to		
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2		27. Manner of Death	28a. Date of Injury	28b. Time	e of 28c. Inju		28d. Describe how		Journey)	
		1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	e 28e. Place of Injury - At	t home, farm, street, factory, office 28f. Location (Street and Nu			et and Number or i	mber or Rural Route Number,		
spital or nours after neral Dire		4 ☐ Homicide building, etc. '(Specify) 29a. Certifier because(s) and manner as stated.								
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H 3 F 8) 50	ny/		26	3632	- 1	0705	12009	
107/		30. Name and address of person who	completed cause of death (Ite	m 23a) (Tyr	De, Print) 85	m s	21061.	STE 12	8 GEN BURNI	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Physic /Med Exam

Funera Directo

Registrar		Certificate of Death						Reg. No. 2 () 1 9 9				
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4a. Facility Name (If not institution, ga		1		ity, Town, or Baltiv		f Death		40	c. County	of Death		
University of Maryland 5. Social Security Number 6.		In vrs. last birt		der 1 Year	If Under 2	24 Hrs.	8. Date of Bir	th		9. Birth	place (S	tate or Fo
	1 □ M 2 X F	Yrs. Months Days Hours			Min.	(Month, Da May 18			·PA	Country)		
Usual Residence of Decedent						,	Tay IO				10d. Inside City Lim	
	State 10b. County 10c. City, Town or Location										Yes 21/2	
10e. Street and Number	eryland Harford Bel Air S. Street and Number 10f. Zip Code 10g. Citizen of What C							What Cou		75		
814 Bynum Run Co	ourt			21015				USA		Wilat Cou	itu y :	
11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec	cedent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No)-	14. Rac	ce - Ameri	can India	ın,
1 ☐ Never Married 2 ☐ Married		If Yes, specify Cuban, Mexican, Puerto								White, etc.		
3 Widowed 4 □ Divorced		TLIYes	Z LZMNO	Specify:		Specify:				White		
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Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) Electric								tor			
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George Washington												
	<u>Porge Washington Helmick</u> Olie Frances (unk) In Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State								, State, Zi	p Code)		
Kimberly H. Hoope	r / daughte	r 814	Kimberly H. Hooper / daughter 814 Bynum Run Ct., Bel Air, MD 21015									
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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth M. Crandall, ND 225

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** William 11:59 2009 Hughes 3 october /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Balhmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 M M 2 □ F Director 80 214-26-6293 <u>Maryland</u> Sept. 1,1929 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 21 No Director Dunda1k Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 hours after death with 21222 United States Funeral 8041 Midhaven Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ≥ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withii Hygiene. 12 should be filed with and Mental Hygier 7 is marked other the Steel Industry Steelworker Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Odelia Koerber Walter Edward Hughes 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau 8041 Midhaven Road Dundalk, Maryland Mrs. Elleen M. Hughes (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10/6/2009 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, ature of Funeral Service Licensee Inc. 21222 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Failur **Physician** 7 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preumonia 11 DAYS Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No peu o. the 9 \ Unknown signed by to ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sh autopsy performe this certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient မ 2 ER/Outpatient 3 DOA After thi funeral of 28c. Injury at Work? 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 OCTOBER 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE, MD SUSAN QUAN MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 6 2009

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 2, 2009 2009 2009 **Physician** 8:30 a M May Howard Anna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkton 801 Dairy Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🙀 F Months Days Hours 219-12-9405 95 31, 1914 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinct must be notified at once. 10b. County 10a. State Baltimore Parkton 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19020 York Road 21120 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 😿 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: \$ White 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Industrial Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Elmer Smi th Christine Yeager ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Dairy Rd., Parkton, MD 21120 Aza Butler-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/07/09 4□Donation 5 [XOther (Specify) Entombment Dulaney Valley Timonium, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD Approximate Interval Between Qnset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** WEEL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine I or Attending Physician: The law requires that the death certificate be executed after death. this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of); P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □Yes 2 \\No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) RESIDENCE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sanatura 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signat 31. Date filed Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 200^{year} 1:30 p M Glenn Arvid Johnson Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 4847 Bonnie View Court Ellicott City Howard 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Hours Min. April B. Year 916 New York 93 Director 095-<u>05-7867</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director or 28a-f sl e notified Maryland Howard Ellicott City 1X Yes 2 No 10e, Street and Number 10g. Citizen of What Country? pe 23a Funeral filed within 72 hours after death with al Hygiene. **Examiner must** 4847 Bonnie View Court 21043 <u>United States</u> items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. ŏ Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**X** No Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White "natural", 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) Engineering Mechanical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rohert Johnson Caroline Carlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Johnson/ Son Bonnie View Road Ellicott City, permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Maryland 21043 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 5. 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State Metro Crematory, Inc. 2009 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Ind. Signature of Funeral Service Licensee Amanda Heaston 209 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, YO St Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Impury that initiated events Due to (or as a consequence of): Exam and burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2. No this certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**V** No Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Dr. Clement Knight 10710 Charter Drive Columbia, Maryland 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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2009

		1 - For State of Maryland / Dep	partment of Health and Nertificate of Death		ene 009 31894		
Physicia /Medic		Decedent's Name (First, Middle, Last) RUTH RISTON JACOB		2. Date of Death Month October	Day Year 2809 10 44 p M 4c. County of Death N/A N/A 9. Birthplace (State or Foreign Country)		
Examina Funeral Director	er	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN NURSING CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 F 87 Vsual Residence of Decedent	4b. City, Town, or Location of Death Baltimore City If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Apr 4, 1			
partitioner, interpretation 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If them 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic event, the Madical Examinar must be notified at once.	To Be Completed by Funeral Director	Amed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7. Father's Name (First, Middle, Last) Frederick William Jacob 19a. Informant's Name/Relationship (Type, Print) Leven C. Leatherbury 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Te City 10f. Zip Code 21239 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerform of Yes 2 No. Specify: edent's Usual Occupation to kind of work done during most of work DO NOT use retired) Ket Clerk 18. Mother's Name of Hispanic Origin? (Sp. North of Work done of North of Yes Petrone) Carmelo Street, Specific (Name of Hispanic) Dount Crematory 10/5	consideration of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the	el City or Town, State, Zip Code) CA 92107 Cc. Location - City or Town, State altimore, Maryland		
To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and book to the funeral Director. After this certificate has been signed by the ettending physician and book to completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of burial-transit.	edical Certification: To Be Completed by Physician/Medical Examiner	Martin D. Lawson MICHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212					
To the twithin 2. To the I complete	5	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item/23a) (Typeran Completed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32 Registrar's Signature	20a Linguag gumbas		Data signed (Month Day You)		
Sta Registra		31. Date filed (Month, Day, Year) OCT Q 6 2009 32 Registrar's Signature	10 Good Sama	ritm	Aursing Colos, Balto		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07602 State of Maryland / Department of Health and Mental Hygiene Vaughn Antwain Jenkins Certificate of Death 1- For State Reg. No 3. Time of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Y September 29, 2009 Physician/ 2130 hrs Vaughn Antwain Jenkins Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** June 25,1987 Hours Months D.C. Director 579-13-3990 22 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any lob. County 1 X Yes 2 No Laurel P.G. MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland near Of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. 20707 14015 Chestnut Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 XMarried Never Married African-American 2 X No Yes Yes 2 X No specify: If Yes, Give Year Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Movers Relocation Specialist 21215-0036 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Gatlin Valerie Jenkins Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 20707 Valerie Jenkins-Mother 14015 Chestnut Street, Laurl, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Landover, MD 1 X Burial 2 Cremation 3 Removal from State 10-7-09 Department of Important: I Harmony Mem. Pk. 4 Donation 5 Other Specify: 22. Name and Address of FacilityBonnette & Assoc. Funeral Home 21. Signa of Funeral Service Licensee permit. 2504 28th St., N.E., WDC 20018 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death 'Medical a. Head and Neck Injuries Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi The law requires that the death certificate be executed Physician/Medical AMENDED g physician a UNPENDED 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year 3 Ectopic pregnancy 3b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 Unknown Completed by Records, P. 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? certificate has funeral director, page 2 1 🗸 Yes ✓ Yes 2 Juission of Vital Ri To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Pi 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ examiner? Residence 6 DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 🗸 Yes Nο 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 27. Manner of Death Driver in auto-fiixed object collision Certification: Sep 29, 2009 2043 hrs Yes 2 V No Natural Pending To the Funeral Director: completely filled in by the 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) Rhode Island Ave @ Fox Street, College Park, MD Suicide determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Windical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

29b. Signature and title of certifier

Carol Allan, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

September 30, 2009

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 038 **Physician** September John lones 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland General Baltimoi If Under 1 Year If n/a 9. Birthplace (State or Foreign Country) 8 Date of Birth (Month, Day, Year) 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex **Funeral** 10 M M 2 □ F Months Days Hours Min. Yrs New Jersey Director 65 7/10/44 212-44-2002 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director MD n/a <u>Baltimore</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or: 1923 Division Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ABORIER or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jones 2 Ester Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Consetto Colbert 1923 Division Street Baltimore, Maryland 21217 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory: 10/6/09 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 23a. Part 1. Prior the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner U 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine in Du lo (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 MNo 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

or Attending Physician; The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

After death. Director: / the Hospital within 24 hours the Funeral

> State Registrar

cal

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signati re and title of certifier

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

investigation

6 Could not be

2 Accident 3 Suicide

4 🗌 Homicide

(Check only one)

29a. Certifier

2 No

Name and address of person who completed cause of death (Item 23a). (Types Print)

Patima 605e, M.D. 301 St. Paul Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Odober JACOBS 2009 12:20 PM ACK Howard 4c. County of Death 4b. City, Town, or Location of Death
Soverna Park 4a. Facility Name (If not institution, give street and number) Soverna Anne Arund 424 Ben Oaks East Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 06/07/1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Country) MD Months Days Mir Hours 1**X** M 2□ F 85 218-14-8002 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 ☐ Yes 2 X No MD ANNE ARUNDEL SEVERNA PARK 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 424 BEN OAKS DRIVE EAST 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEER** MECHANICAL ENGINEERING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SOL **JACOBS** FLAX GERTRUDE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) STUART JACOBS / SON 424 BEN OAKS DRIVE EAST, SEVERNA PARK, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State HEBREW YOUNG MEN 10/05/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE. prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each life. Part 1. Enter the diseas hock, or heart failure. 3 months Immediate Cause (Final Kenal disease or condition resulting in death) to (or as a consequence of) Years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery Month Day Year co use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No No.

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-tra physician the

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

of Health a

item 27 other t

Department o Important: If i any injury or once. = 5

use as been signed by the should be detached cate has bage 2 si certificate this After th funeral

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neral Director: Af
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the Hospital within 24 hours a

Division of Vital Records, P.O. Box 68760,

lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of d.		
Physician/Medica	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	
Completed by Ph	Sleep apnea, A	contributing to death but not resulting in thrial fibrillation, Non	rmal pressure hydroceph	23e. Did tobaco
Be Com	25. Was case referred to medical examiner?		26. Place of Deat	performed 1 □ Yes 2 h (Check only one)
_		Unamital:	Othor	

- 1		
	25. Was case referre examiner? 1 ☐ Yes 2 ☑ N	
	27. Manner of Death 1 ☑Natural	5 ☐ Pending investigation
	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined

10	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	OA Other: 4 \sum Nursing F	lome 5 Residence	6 ☐ Other (Specify)
5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	iry occurred
6 ☐ Could not be determined		ome, farm, street, factor	ry, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
Certifying Ph	ysician: To the best of my kn	owledge, death occurre	dat the time, date and plac	e, and due to the cause(s) and manner as stated.

(Check only one)			xamination and/or investig	ation, in my opinion, death occurred at the time	
29b. Signature and	Vile of certifier	acots	am	29c. License number 00022483	October 3, 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) October 3,2009

State Registrar

STUART 31. Date filed (Month, Day, Year)

Nospita Dr. Glen Burnie mo 21061 JACOBS 305 32. Registrar's Signature

Certification: To

Medical

			For State Registrar	State of Ma	ryiano		rtificate of		а мептаг ну	/giene Reg. No	Por television from Sec.		891
	Physici		1. Decedent's Name (First, Mic Elaine	C. Korb					2. Date of De Month	Da	•	3. Time o	of Death 31P M
	/Medio		4a. Facility Name (If not institu	tion, give street and number)			4b. City, Town, o	Location of De			. County of Death	1	211
	Funeral Director		5. Social Security Number 399-14-2539	more Medical (6. Sex 7. Age		ast birthday)	Towson If Under 1 Year Months Days	If Under 24 h	Hrs. 8. Date of Bi lin. (Month, D Apr 5	rth ay, Year) , 192	Cou	place (State	
_	and		Usual Residence of Decedent 10a. State 10b. Cour	ntv	10c. City	, Town or Lo	cation				11	10d. Inside (City Limits
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1.1	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 6607 Mt. Vi	sta Road			10f. Zip Code	1087		10g. Cit	tizen of What Coul	ntry?	
A 1 N 6 1036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ire Modical Examinat must be notified at once.	by	11. Marital Status 1 Never Married 2 X M 3 Widowed 4 Divorce	If Yes, Give			Was Decedent of H fYes, specify Cuba I □Yes 2 🛛 No		? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: W		
E [A]	nin 72 hc e. nn "natu l Medical	Completed	(Specify only hig	lent's Education hest grade completed)		16a. Deced (Give life. I	dent's Usual Occup kind of work done OO NOT use retired	eation during most of d)	working	16b. K	ind of Business/In	dustry	
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N y	hould id Mer marke matic	우	Hubert 19a. Informant's Name/Relation	Schneider		10b Mailir	an Address (Street		eline r Rural Route Numi	har City	Beh		
∑, aª	and 2 sl ealth an n 27 ls i	1	George P. Kor			6607	Mt. Vis	ta Rd.,	Kingsvi				
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	n 3 □ Removal from State (Specify)		ace of Dispo emetery, cren aney	sition (Name of natory or other place alley	ce) 1C	Date 0/07/09		ocation - City or To monium, N		
Balt	permit Depart Import any Inj once.		21. Signature of Funeral Servi	ce Licensee William	G. D	au 22			Ruck Tows Towson, I		uneral Ho 21204	ome, I	nc.
	Physician	6 9	shock, or heart failure. L Immediate Cause (Final disease or condition	or complications that caused ist only one cause on each line	the death	. Do not ent					8	Approxima Interval Be Onset and	etween
	/Medical Examiner		resulting in death)	Due to (or as a	erran in	ence of):	ranadi.						
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68760,	icate be executed physician and the burial-transit	edical Exa	resulting in death) Last	cDue to (or as a	consequ	ence of):							
	± 6 8 8		IF FEMALE.										
.O. Box	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal	death 3 [Ectopic pregnand Other (specify)	y .			23d. Date of deliv Month	ery Day	Year
σ.	s that gned b e deta	by Pr	Part II. Other significant cond	litions contributing to death bu	t not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to t	the cause of	death?
ord	equire sen sig ould b	led t	subdinical h	yperthy widism					_ 1 🗆	Yes 2	XNo 3□ Pro	bably 4 □] Unknown
Division of Vital Records,		Completed							— 24a. Waa auto perl 1 □ Yes	opsy formed?	death?	ompletion of	s available cause of
Vita	Physician: r this certific ral director, I	Be	25. Was case referred to medi examiner?	Hospital:			Oth	or:	Death (Check only				
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ion	Attending ir death. ector: After by the fune	atior	1 Natural 5 Pen 2 Accident inve	ding (Month, Day, stigation	Year)	Injury		ḱ? Yes 2 □ No					
Divis	al or Atte s after de il Directo ed in by th	Certification:		Id not be armined 28e. Place of Injurbuilding, etc.	ry - At hor (Specify	me, farm, str	eet, factory, office		28f. Location City or To	(Street ar	nd Number or Rur e)	al Route Nu	ımber,
6	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C		ying Physician: To the best o cal Examiner: On the basis of and manner stat	examinat								(s)
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			harjoy	MD MD				60567	F	oct	20cv 4,2	2009	
•			30. Name and address of pers					Baltima	rr. Lama	low	d 2120 4		
	Sta		31. Date filed (Month, Day, Ye.	ar) 32. Registra	r's Sign	ure	Kel	·~ L/WIND	C) NIMY	1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2 2009 ear Elva Fern Kelly 10:34 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Care Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1927 (Month, Day Days Hours 1 □ M 2 🛱 F 82 Maryland Yrs Director 217-22-7738 Jan. Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Sparks 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 20 Rain Flower Path #202 21152 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Legal Secretary Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ pe John Henry Ossmus Hazel Viola Bosse permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Apt. B Garden Road Towson, MD <u>John M. Kelly, Jr.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery 10/5/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimoré, 23a. Part 1. Enter the disease, or compl ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): MONTHS Medical Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner the attending physician and thed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical pe that the death certificate IF FEMALE: f yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death

Physician/

Q

215-0036

7

Maryland

Baltimore,

P.0.

Records,

Vital

law requires

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

SEVERE AGRITIC STENOSIS

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 X No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural

Accident

Suicide

5 Pending Investigation 6 Could not be 4 Homicide determined

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at injury M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

City or Town, State)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number,

HOSPICE

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) 164395

OCTOBER 2, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD 6565 NOMARLES ST, SUIT 216 BATTMERE, MO 2,204

State Registrar

Be Completed by

Certificate:

Medical

the funeral director, page 2 should

has

After this certificate

To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After

31. Date filed (Month, Day, Year) 32. Registrar's Signature parker 09-07623 Rodney Lewis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Physician/ Month Day Year September 30, 2009 1605 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death c. County of Death **Baltimore County** 9508 Liberty Road Randallstown 8. Date of Birth(MM/DD/YYYY) 9, Birthplace (State of 7. Age (In yrs. last birthday) If Under 24Hrs. 5. Social Security Number If Under 1 Year **Funeral** 6 Sex Months June 17.1954 Hours Director 1XM Country) Usual Residence of Decedent 10d. Inside City Limits 10b. Co Location Yes 2 No Randallstown timore must be notified at once. Director Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Yes Yes 2 No specify: f Yes. Give Year Widowed Divorced traumatic event, the Medical Examiner 2 Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last ks Name First, Middle, Maiden S Be mant's Name/Relationship (Type, Place of Disposition (Name of cep of Disposition Owings Mil Burial AXTISONO FOREST 2 Cremation 3 Hemoria Other Specify Donation 5 2140

nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear

X AMENDED 10c,19b,20a-c, perFh g896 10/27/09 TT

Fetal death

Other (Specify)

a Multiple Sharp Force Injuries

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Live birth

Unknown

9

Hospital: 1

23c. If yes, outcome of pregnancy

Pregnant at time of death

Inpatient 2

28a. Date of Injury

Sep 30, 2009

Baltimore, Physician /Medical `xaminer

If item 27 is

other than "natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene.

MD 21215-0036

signed by the attending physician and be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, funeral director, page 2 should

within 24 hours after death. To the Funeral Director:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Physician/Medical ģ Completed 25. Was case referred to medica æ examiner?

cal

(Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 3b. Was decedent pregnant in the past 12 months 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Immediate Cause (Final disease

or condition resulting in death)

1 ✓ Yes 27. Manner of Death Natural Pending filled in by the 2 Investigation Accident 3 Suicide 4 V Homicide 29a. Certifier 1

28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be determined (Specify) Single Family Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

and manner stated. 29b. Signature and title of certifier

Theodore M. King, Jr., MD. Assistant Medical Examiner

ER/Outpatient 3

0000 hrs

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

3 Ectopic pregnancy

26.Place of Death (Check only one)

Other₄

Yes 2 V No

28c. Injury at Work?

O.C.M.E.

DOA

OCME

Nursing Home 5

24a. Was an

autopsy

performed? ✔ Yes 2

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) October 1, 2009

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Yes 2 No 3 Probably 4 V Unknown

death?

Residence 6 V Other: Scene

28f. Location (Street and Number or Rural Route Number, City

Subject sustained sharp force injuries

or Town, State) 9508 Liberty Road, Randallstown, MD

1 V Yes

Day

24b. Were autopsy findings available prior to completion of cause of

Approximate Interval

Between Onset and

Death

Year

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month Registra

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ <u>An Van Lam</u> Medical 27, 2009 4:30 P 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson **Baltimore** Gilchrist Hospice Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year) Country) Director Vietnam 586-16-9406 Aug 27, 1939 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD **Ellicott City** Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4605 Broken Lute Way 21042 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Vietnamese 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lieu Thi Lam Phu Dang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Nu To Loi spouse 4605 Broken Lute Way Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State any injury 4 Donation 5 Other (Specify) Oct 05, 2009 Ellicott City, MD John's Cemetery Single of Funeral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MOXIC Ini brain days disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardiac 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) 6 1 ch ist 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending injury

the attending physician and hed for use as the burial-transi that the death certificate be P.O. ate has been signed by page 2 should be detach r Attending Physician: The law requires Records, within 24 hours a 'er death.

To the Funeral Director: A'ter this certificate h by the funeral director, Division of Vital Hospital

be filed within 72 hours after death with the Maryland

Page 1 and 2 should

Maryland 21215-0036

Baltimore,

200

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A

8

work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R149194 September 28, 2009 RNP

arked

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

Marian Gmt, 6701 N. Charles, Towson, MD 21204

State Registrar

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** 4:10 A M October 1, 2009 John Daniel Lombard /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2 □ F Yrs. New Jersey Mar. 8, 1926 83 Director 156-18-6409 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Toyin or Location 10a. State item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 1404 Midhurst Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. ρ Baltimore, Maryland 21215-0036 3X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chiropractor Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Vincent (nmn) Lombardi Angela Maria Prete ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1404 Midhurst Ct., Bel Air, MD 21014 Tom Murtaugh / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Oakland Fraternal Cem. 10-7-09 Little Rock, Arkansas 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner END STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Denonta hyportolos torelomia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No Vital al or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ Division or 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier X Name and address of person who completed cause of death (Item 23a) (Type, Print) 415 W. MacPhailRd. Suite 104 Bel Air, Mb 21014

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

06

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 05 Day 2009 Vear Α. Jr. Thomas Lane 12:26 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Marley Neck Health and Rehab. Anne Arundel County Glen Burnie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 6, 1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary Land Months Days Hours Min. 220-20-2125 1 M M 2 □ F 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23 or 28a-f show 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Evander rust be notified at **Funeral Director** Maryland Anne Arundel Pasadena 1 ☐ Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 363 North Ferry Point Road 21122 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 □ No fYes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Ş Q 3 Widowed 4 Divorced Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City 12 Attorney at Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Urbanski Thomas A. Lane Sr. Lucia ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elise A. Lane (Wife) 363 North Ferry Point Road, Pasadena, Maryland 21122 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ٥ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If injury Crownsville VA Cemetery Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oct. 08,2009 21. Signature of Funeral Service Licen 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death uniediate Cause (Final Men **Physician** 4 Pars Isease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

15 Hornaral Director: After this certificate has been signed by the attending physician and the premaind provided the provided physician and prebly filled in by the furneral director, page 2 should be detached for use as the buriela-transit Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 □ NO 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 46 25. Was case referred to medical 26. Place Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 □ 10 Certification: To 1 🔲 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a, Certifier 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Thner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month Day, Year)

DHMH 17 Rev 1/2001

State Registrar 30. Name and address

31. Date filed (Month. Day.

of

odlia

who completed cause of death (Item 23a) (Type, Paint)

Registrar's Signature

Daky

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year September 21, 2009 12:22 PM **Physician** Antoine E. Lewis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Sept 20, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Year. Days 1**∑** M 2□ F 1948 Virgin Islands 580-12-3658 61 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2√□No Director Clinton MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 9211 Stuart Lane 20735 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.S. Armed Forces? arried 1 □ Yes 2 K No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: black. Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) maintenance worker hospital unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacie Mattock/friend 228 Ring Farm Road Whitestone, VA 22578 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 MOther Specify) in state 21. Sign ture of Eureral S ce Licensee S . Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Patt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause weach line. Approximate Interval Between Onset and Death Immedia Cause (Final disease of condition resulting in ath) 4 as mo intertional Hemomhaye Esonhas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 seconday 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ ¥6 2 🖼 🗸 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760, P.O. n signed by the a Id be detached fo Division of Vital Records, been si has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Certification: To

Funeral

Director

show

77 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Wodes | Eran, inc. must be not the

tal Hygiene.

h and Mental h and 2 should be

Department of Health a Important: If item 27 is any Injury or other tranonce.

Physician

/Medical

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

(Check only one)

29b. Signature and title of

30 Name and address of

~e(

1328 Jouthern avenue Il Jack 310 Workington De 20032 31. Date filed (Month) 32. Registrar's Signature parked Leneur

amer

and manner stated.

(PM

MD

erson who completed cause of death (Item 23a) (Type, Print)

D0055120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 2, 2009 F. Lewandowski 7:30 A.™ 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death FutureCare-Canton Harbor Baltimore City If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours Min. 196-18-5208 84 4-4-1925 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits X∏Yes 2 ☐ No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 517 South Belnord Avenue 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1X Yes 2 □ NWWII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: White Specify: 3℃Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mill Wright <u>Bethlehem Steel</u> 18. Mother's Name (First, Middle, Maiden Surname) (UNK) 17. Father's Name (First, Middle, Last) Ignacy Lewandowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Lewandowski-2729 Eastern Avenue Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cem. 10-6-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Kaczorowski Funeral Home, P.A 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dub to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Fetal regnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Pulmonary 3 Probably 4 Unknown

/Medical **Examiner** uires that the death certificate be executed P.O. Box 68760 detached Division of Vital Records,

Physician

/Medical

Examiner

10a, State

Director

Funeral

Completed by

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Merical Event and the notified any Injury or other traumatic event, I'm Merical Event and the notified any Injury or other traumatic event, I'm Merical Event and the notified any Injury or other traumatic event, I'm Merical Event and I was any Injury or other traumatic event, I'm Merical Event and I was any Injury or other traumatic event, I'm Merical Event and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a second and I was a se

Physician

Baltimore, Maryland 21215-0036

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Physician: this certific al director,	ည	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient	з □ DOA	Other: 4 🛭 Nursing H	lome 5 Res	idence 6	☐ Other (Specify)			
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ox 1		30. Name and address of person who Dr. Chintan D	completed cause of death (Item esai, M.D. 30	1 23a) (Type, Pri	Paul	Place,P.	O.B.#5	519 E				
		D4 Data filed (Month Day Vens)	00 Maintenale Ciano									

Registrar

OCT 0 6 2009 Shows B. Sares

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month GARY 2:20 AM 04 2009 Physician MANDERS 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE BALTIMORE VA MEDILAL CENTER 9. Birthplace (State or Foreign Country) DISTRICT F Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Yrs. 217-42-3895 600 12,29,1942 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☑ No Riva Directo Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21140 2727 Crestview Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1964 If ¥es, Give Year or Dates: 1966 11. Marital Status 1 Never Married Married 1 ☐ Yes 2 ☑ No Specify. Specify: White Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event". College (1-4or 5+) Elementary/Secondary (0-12) Fire & Rescue Firefighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Hammell Robert W. Manders ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2727 Crestview Road Riva, Maryland 21140 Jeri Manders, Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 10/06/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Alice Iser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CELL LUNG CANCER NON SMALL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🔼 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1962637892 enneth D. 10,4,2009 Tillenburn, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE VA MEDILAL CENTER KENNETH D EICHENBAUM, MD NORTH GREENE STREET BILTIMORE, MD 21201 ID

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State Registrar					•	rtificate					Reg.		00	3119	07
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be completely filled. Destriction To Re Commission To Recommission hy	Certification: 10	1 Matural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier (Check only one) 5 ☐ Pending investiga 6 ☐ Could no determin 2 ☐ Certifying 2 ☐ Medical E	tion t be 28e. Place of Injury - At building, etc. (Spec Physician: To the best of my k kaminer: On the basis of exami and manner stated.	nowledge, deanation and/or	ath occurred at the investigation, in a 29c. Lice	ne time, date and placemy opinion, death occurrence number	e, and due to the caurred at the time, da	ause(s) and manner ate and place, and coordinate and place, and coordinate signed (Mc	r as stated. due to the cause(s) onth, Day, Year) 2, 2009	

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MAISEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 200 /Medical County of Death 4b. City, Town, or Location of Death Examiner **Funeral** Days 1 □ M 2 ₩ Months Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f shov ortant; if item 27 is marked other than "natural", or items 23a or 28a-f shor Injury or other traumatic event, it a Mudical Examinar must be notified at 1 ☐ Yes 2 Mo Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code USA 2/20 Funeral Oa. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ∐Yes 2 № If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 17. Father's Name (First, Middle, Last) Be Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 is 1 40.MD 21239 lar 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other p 1 We Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aortic **Physician** Dissection /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a P.O. 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Pulmonary Embolism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 **N**0 1 ☐ Yes 2 🗆 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation Injun 1 □Yes 2 □ No death. 2 Accident Director: , 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direc 4 Homicide 29a. Certifier t 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 29c. License number D46052 10/02/09

State Registrar

31. Date filed (A

medical

annapolis, MO

30. Name and address of person who completed cause of death (Item 23a) (Type Print),

2001

32. Registrar's

reid Bech, MW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE KaHIMOre Munder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Social Security Number 11-26-2082 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F Months Yrs. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No HIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Tyra Mouzen 19a. Inform s Name/Relations p (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OF Dementia につらり PICA 1124 Due to (or as a consequence of). Sequentially list conditions, if any leading to a modern cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death A Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liquity or other traumatic event, it is "Medical Evaniner must be notified at once.

2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

Box 68760.

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Records,

of Vital

Division

To the Hospital or Attending

within 24 hours

Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician/Medical 2 Completed After this certificate has

မ To the Funeral Director: After th completely filled in by the funeral Certification:

3 Suicide

29a. Certifier

4 ☐ Homicide

27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 5 ☐ Pending investigation 2 Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 🗆 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated 29b. Signatury

6 ☐ Could not be

address of person who completed cause of death (Item 23a) (Type, Print)

NES 31. Date filed (Month, Day, 32. Registrar's S

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day <u>5:4</u>0 P^M September 30, 2009 David Lee Mills 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3714 Bold Ruler Court Glenelg Howard 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 MM 2□ F Months Days Hours Min Yrs. 9/24/58 Maryland 214-70-5615 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐Yes 2 X No Howard Glenelg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3714 Bold Ruler Court 21737 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 四 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BGE Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Marmer Ethel Virginia Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jeanette M. Mills / Wife</u> 3714 Bold Ruler Court Glenelg, Maryland 21737 20a, Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 ☑Other (Sperittombment Cedar Hill Cemetery 10/5/09 Brooklyn Park, MD. 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licen 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Tastat months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral Director

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exprinter man be recitified at once.

Baltimore, Maryland 21215-0036

physician and the burial-transit

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Examine Physician/Medical ۾ Completed Be

Certification:

Medical

29a. Certifier

the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🗶 attending pl ed by the a signed t icate has been signicate has been significated by page 2 should b certificate this After after death

Director: /

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

(Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mi 10710 Dr. WARD CHANTER CownBU

State Registrar

31. Date filed (Month, Day, Year) OCT 0 6 2009

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within 2 To the I

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** O S Machin mma 2:00 A M 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Elizabeth Nursing Baltimore n/a 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 1 ☐ M 2 ☐ F Months Days Hours 216-12-5254 86 Director 12/28/1922 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rral", or items 23a or 28a-f shov Evaruitwee, ust be notified at Director 1 Yes 2 □ No n/a MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3300 Benson Avenue 21227 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2X No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Completed by White Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 0 Marion Scandora Angelina Pirozzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Machin / Son 1 Lynhaven Court, Severna Park, Maryland 21146 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Ceme. 10/8/2009 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Signature of Funeral Service Libenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician (HF disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe mitral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) ospital or Attending Physician: The law requires that the death certificate be executed hours after death. use as the burial-trai Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2016 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ý determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12111615 CRIP 1015109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Goldsborough 3 Baltimore Ave 31. Date filed (Month, Day, Year) 37. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Box 68760,

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Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 Day 2009 ar **Physician** 6:15a M William D. Magsamen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 8920 Mayflower Road Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Ye Aug • 9 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Year) 1947 **Funeral** Days Hours Months M 2□ F 212-50-5325 MD 62 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at MD Baltimore Rosedale 1 ☐ Yes 2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21237 USA 8920 MAyflower Road death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Fabricator Iron Worker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Charles H. Magsamen Ruth Krouse traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 states to Department of Health an important: if item 27 is any injury or other trauonce, Donna Magsamen /wife 8920 Mayflower Road Baltimore MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/8/09 Owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licensee 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part1. Enter the diseast, or contact tions that cause whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 0 **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner A Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events southing in death Last Due to or as a consequence of Examine The law requires that the death certificate be executed ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) been signed by the s should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has rai director, page 2: autopsy Yes 2 No 1 ☐ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 ☑ Natural 2 ☐ Accident (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director; completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

15

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TIEM#5perFH, 6896, 10/21/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 0120 PM Betty May Mort OCTOBER 04 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 249LS240028 6 Sex 7. Age (In vrs. last birthday) **Funeral** Year, Months Days Hours Min 1 M 2 X Yrs. 219-30-0023 Kentucky 22, 1938 Feb. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County show id other than "natural", or items 23a or 28a-f shovevent, it a Maxical Examir er must be redified at N/A Maryland Baltimore XXYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3712 Falls Road 21211 USA Funeral death 1 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ► No 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2XXIIIo Specify ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Its IMa once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Fred Cunningham Ida May Fisher ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Willard Clyde Mort, III Son 3712 Falls Road, Baltimore, Maryland 21211 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2XX remation 3 ☐ Removal from State Atlantic Crematory 10/08/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 21. Signature of uneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 19min **Physician** resora /Medical Due to (or as a consequence of Examiner provasc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine neverno or Attending Physician: The law requires that the death certificate be execute burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 DANo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

201 E. UNIVERSITY EVA DI 600 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

6000

29c. License number

1598990624

29d. Date signed (Month, Day, Year)

04 2009

OLTOBER

BALTIMORE, MD - UNION MEMORIAL HOSPITAL

			, 101	eartment of Health and Meartificate of Death	ental Hygier	5000 0101
	Physici	an	1. Decedent's Name (First, Middle, Last) Lucille Montgomer		2. Date of Death Month	Oay Year 3. Time of Death
i ma	/Medic Examin	cal	Lucille Montgomer 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	0-11	3 , 2009 03. 48 / M
ner"			ST. AGNES HOSPITAL	BALTMORE		NA
	Funeral Director		5. Social Security Number 217-30-4696 6. Sex 1 M XXF 7. Age (In yrs. last birthday 1 M XXF 81 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 0 7 – 1 3 – 28	9. Birthplace (State or Foreign Country) SC
	/land iow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	e Mar	ctor	MD NA Baltimo	re		XiXiYes 2□No
	with the	Dire	10e. Street and Number 1902 Lauretta Avenue	10f. Zip Code 21223	10g.	Citizen of What Country?
	death	Funeral Director	11 Marital Status 12 Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto F	cify Yes or No-	USA 14. Race - American Indian,
38	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, it is investigal Event far must be notified at	by Fu	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No If Yes, Give Year or Dates:	1 □Yes XINO Specify:	ilcan, etc.)	Black, White, etc. Africar Specify: American
Maryland 21215-0036	72 hou 'natura	Completed by	15. Decedent's Education 16a, Dec	edent's Usual Occupation	α I	Kind of Business/Industry
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nd		Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Surname)
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Baltimore,	of Hez					Location - City or Town, State
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Ва	permit. Departr Importa any Inju					timore, MD 21217
			2.1 - art 1. Enter the disease, or constitutions that caused the death. Do not en shock, or heart failure. List (18) one cause on each line.		respiratory arrest,	Approximate Interval Between
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ם ס	ding P	tion:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 28a. Date of Injury (Month, Day, Year)	of 28c. Injury at Work? M 1 □ Yes 2 □ No	8d. Describe how in	jury occurred
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 ☐ Rucide 1 G ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	1 3 1 3 1 2 1 1	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
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,	the Hothin 24 the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated. 29b. Signature and title of cartifier	nvestigation, in my opinion, death occurre	d at the time, date a	and place, and due to the cause(s)
	Z W Z	_	29b. Signature and the or carther M.O.	29c. License number D 0 0 6 2 6 3 4		CT&BER 3, 200 9
			30. Name and address of person who completed cause of death (Item 23a) (Type MATEEN AVAN 10812 F	FICKORY RIDGE DA		
	Sta		31. Date filed (Month, Day, Year) OCT 0 6 2009 32. Registrar's Signature from	الما		
DUA	Registr	air	ACI 0.8 5002 Vends 12. 14.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 3.40 AM TOBEZ: 2009 **Physician** Sylvia M. McLaughlin /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BURNIE en se WEN SAETIMORE WASHINGTON MEDTICAL CENTER 8. Date of Birth (Month, Day, Feb 12, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Mary land **Funeral** Hours Months Days Min 1 □ M 2 🗓 F 1926 220-12-5343 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2√2 No Director Pasadena MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 21122 USA 8163 Orchard Point Road or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🙀 No Specify: white ģ 3 X Widowed 4 ☐ Divorced "natural" Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4or 5+) hanking manager marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental h should be John Henry Tonkin May Liddicoat ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21060 1 and 2 99 Glen Road Glen Burnie, MD John D. McLaughlin/son Important; If Item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 t o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 ☐ Other (Specify) Ronal Califer W State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1. Immediate C se (Final disease or con in the resulting in death) CONGRETINE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical The law requires that the death certificate the as attending IF FEMALE: use a 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year þ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed .24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performe 2 🗆 No 2 No 1 ☐ Yes 1 □ Yes ospital or Attending Physician; hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ∕ 2 **√**No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after deau..

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20161

State

Registrar

31. Date filed (Month, Day, Year

0 6 2009

32. Registrar's Signa

			For	tate of Maryland /				ental Hygie	ene	10 2101	-7
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36	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene do the than "natural" or Items 23a or 28a-f show dother than "natural" or Items 23a or 28a-f show event, the Maulical Examinar must be notitied at event, the Maulical Examinar must be notitied at	by Fi	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Speci	^{fy:} White	
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<u>∞</u>	is 1 and 2 soft Health artitem 27 is other trau		Mrs. Edna Marie M		949	Dalton A	ve. Balt	imore, M			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene Important: If item 27 Is marked other than "natural", or litems 23a or 28a-f show amy injury or other traumatic event, the Marylial Examinat must be notified at once.	4	21. Sign ture of Funeral Service Licensee	20	I	Name and Address Ouda-Ruck 7922 Wise	Funeral	Home of undalk,	Dunda Maryla	1k, Inc. and 21222	
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		atė	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	е						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day 30200 Year 3:16 Murray 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year) If Under 1 Year (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex Months Days Hours 1 ☐ M 2 🖾 F 07/01/1917 213-16-9149 92 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 10623 Rivers Bend Lane 20854 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Admin. 12th Records Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hattie Hunt Edward Skinner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10623 Rivers Bend Lane, Potomac MD 20854 Gareth E. Murray/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/07/2009 | Columbia, Md 4 ☐ Donation 5 ☐ Other (Specify) Columbia Mem. Park Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 -Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute disease or condition resulting in death) Due to (or as a consequence of): APOLAC Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed 26. Place of Death (Check only one)

Physician /Medical Examiner

and

physician

death certificate be executed

The law requires that

certificate Physician:

this

24 hours a

To the I within 2 To the I

Box 68760

P.O. I

of Vital Records,

Division

Physician

/Medical

Examiner

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MD

Funeral

Director

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Director

Funeral

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item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Madical Exeminat must be notified at

within 72 hours after death with

Baltimore, Maryland 21215-0036

2 should be finance and Mental F

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev

Examine as the burial-transi Physician/Medical the attending p signed by the a d be detached for ۾ icate has been si , page 2 should t Completed completely filled in by the funeral director, Be ည PHOSpital or Attending Pt 24 hours after death.
Funeral Director: After the Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □No 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 17 No 1 🔲 Inpatient 2. ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

DHMH 17 Rev 1/2001

State

31. Date filed (M Registrar

Medical

29a. Certifier

29b. Signature and title of Certifier

of person

lare

30. Name and address

who completed cause of death (Item 23a) (Type, Print)

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MO-9901 Medical Center Drive, Rockiste, Md. 20850

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year MARKS 2009 OCTOBER SELIG 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sex 1M M 2□ F Days 219-10-2175 83 10/28/1925 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2X No WESTMINSTER CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21157 770 FOUR SEASONS ROAD 12. Was Decedent Ever in U.S. Apped Forces? 1 Myes 2 □ No WWII If Yes, Give Year or Dates: NAVY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: WHITE 1 □Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TIRE SALESMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BASH0FF **MARKS** BESSIE CHARLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 770 FOUR SEASONS RD., WESTMINSTER, MD 21157 SYLVIA MARKS / WIFE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/05/2009 BALTIMORE, MD HEBREW FRIENDSHIP 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee KUC 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RENAL CELL Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

MD

Director

Funeral

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Completed

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Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hyglene.
unt: If item 27 is marked other than "natural", or iter

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Saltimore, Maryland 21215-0036

death with

attending physician and for use as the burial-transi been signed by the should be detached cate has t funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

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After

n 24 hours after death.

Per Funeral Director: A sletely filled in by the funeral properties.

within 2

Division of Vital Records, P.O.

Box 68760,

Examiner Physician/Medical ģ Be Completed Certification: To

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 XVo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes 2 No 27. Manner of Death 1 XNatural

29a, Certifier

(Check only

2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 ☐ Could not be

2 ☐ Medical Examine

28a. Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

ROAD. RANDALLSTOWN MD 21133

and manner stated. 29b. Signatu

D0060293

29c. License number

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) OCTOBER 1, 2009

2 No

30. Name and address person who completed cause of death (Item 23a) (Type, Print) AHMED.

31. Date filed (Month, Day, Year)

OLD COURT 5401 32. Registrar's Signature

State Registrar

Medical

Mia Lynn wichols
09-07515 F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2009 3192							
Physici Medical Exami		1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death							
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							
		Woods near 2200 Ridge Road Windsor Mill Baltimore County							
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Foreign Country)							
		Usual Residence of Decedent							
0w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No							
aryland 8a-f sh at once	Director	10e. Street and Number 10g. Citizen of What Country?							
5 72 hours after death with the Maryland n "matural", or items 23a or 28a-f show any al Examiner must be notifited at once.		3901 W FOREST PARKAVE 21207 USA							
eath wit items 2 ust be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Married 4. Race - American Indian, Black, 4 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, Black, White, etc. White, etc.							
	by Ft	3 Widowed 4 Divorced If yes, Give Year or Dates: 1 Yes 2 No specify: Specify: Specify:							
hours afte "natural", Examiner		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry							
₩ = 5.2	Completed	Assistant Director Social Worker							
21215-0036 puld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)							
212 ould be d Ments s mark	To B	19a. Informant's Name/Relationship (Type, Print) Gather 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
MD and 2 sho salth and 2 rem 27 is raumati	_	Clarence E Nichols 508 Henry Dr. Millville, NJ 08332							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		1 Burial 2 Cremation 3 Removal from State Crematory or other place							
altin rmit. P ppartme ipportan		21. Signature of Funeral Service Licensee / / (22. Name and Address of Facility House)							
		/ Suant Howll or P.O BOX 26547. BEID. NO 2407							
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wounds (2) of Head Approximate Interval Between Onset and Death							
`xaminer	Immediate Cause (Final disease or condition resulting in death) a Gunshot Wounds (2) of Head Due to (or as a consequence of):								
	ě	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
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50, te be ex nysician	fedical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery							
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D.O. Box 6876 that the death certifical red by the attending pheterached for use as the	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown							
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Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical 26.Place of Death (Check only one)							
of Vid	리	1 Yes 2 No Tospital 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other: Scene							
ion of tending Ph eath. or: After the funeral	Certification:	1 Natural 5 Pending 9.26 / 09 found 9:30a							
Division al or Attendi rs after death. al Director: A	tifica	Accident investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City of Town, State)							
lospital t hours uneral		4 y Homicide UNKNOWN UNKNOWN							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	293. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
	-	30. Name and address of person who completed cause of death (Item 23a)							
101		Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
St Regist	-	31. Date filed (Month, Day, Year) 32 Registrar's Signature							
•		VVI VI EUV							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G896, 10/30/09 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2,2009 **Physician** MARY M. NIEBERLEIN ctober /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Samaritan Hos more
If Under 24 Hrs. N/A Birthplace (State or Foreign Country) MD 8. Date of Birth 7. Age (In yrs. last birthday) 212 ial 12 uri 0751 er **Funeral** 1 □ M 3 ₽ F Months Days Hours Min. AUGUST^{Day}18^{ar}1921 88 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I've Madical Evan har must be notified at 1X Yes 2 No Funeral Director N/A BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4411 WHITE AVE 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Menta LILLIAN DICKERT FRANK DICKERT 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1736 FORREST AVE BALTIMORE, MD 21234 19a. Informant's Name/Relationship (Type. Print) ROBERT NIEBERLEIN-SON item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Himportant: If ite any Injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/6/09 BALTIMORE, MD HOLY REDEEMER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) trial Physician brillation /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 K No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, within 24 hours a

To the Funeral I

be filed within 72 hours after death with

Mental

21215-0036

Maryland

Baltimore,

Pages 1

Niebenlein

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

60

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUGENE

Year)_

			Please	Type or Prin	t in Black In	delible Ink	Ensure A	II Copies	Are Legible	a.	
			_ For	State of Ma	ryland / Depa			1ental Hyg	giene		
			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	K 34422	
	Physicia	an .	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	Day Ye	3. Time of Death	
	/Medic		Wanda E.	0eser		4b. City, Town, or Location of Death			2, 2009 4c. County of E	2:35 P M	
*	Examin	er	4a. Facility Name (If not institution, give						Balti		
1	Funeral	-	5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year		8. Date of Birtl	n 9.	Birthplace (State or Foreign	
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	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
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	the N 28a-f otifie	Directo	Maryland Baltin 10e. Street and Number	nore	Timo	10f. Zip Code			10g. Citizen of Wha	it Country?	
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	death ms 2 r mus	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.		Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		American Indian, White, etc.	
و	after or ite	/ Fu	1 ☐ Never Married 2 【X Married	1 ☐ Yes 2 💯 N	lo	1 ☐ Yes 2 No		7 (1001)	Specify:		
9500-61212	e filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		edent's Usual Occup	nation		16b. Kind of Busin	White	
ر ا	n 72 l ''nat edica	Completed	15. Decedent's Education (Specify only highest graduation)	ade completed)	(Give	e kind of work done DO NOT use retire	during most of worked)	ting	TOD. KING OF BUSIN	ess/moustry	
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<u> a</u>	uld be Venta Irked Itic ev	To E	Faustyn	Geriel	c		Sopl	nia Sma	rowski		
Maryland	2 sho and f Is ma auma		19a. Informant's Name/Relationship (and Number or Rui			ite, Zip Code)		
≥ .	and lealth m 27 her tr		William Oeser/Hu	ısband	213 20b. Place of Disp		ldge Road,	Timoni	um, MD 2	21093	
0	iges 1 nt of H if ite or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □		cemetery, cre	ematory or other pla	10/6	5/09			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Immortant: If tiem 27 is marked other than "natural; or items 28 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral 21.	nse		Valley Me	emorial Ga	ardens	Timonium,	, Maryland	
Вa	Depa Impo any i		Michael J.	212	T.	emmon Fur	neral Home onia Road	e of Dul	aney Val	Ley Inc.	
			23a, Part1, Enter the disease or com	plications that caused	the death. Do not er	nter the mode of dyi	ing, such as cardiac	or respiratory a	rest,	Approximate Interval Between	
e F	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each in	hyo cardi	ial Ing	farct			Onset and Death	
2	/Medical		resulting in death)	Due to (or as	a consequence of):					- 111/0/15	
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4	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
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189	ertificate be ng physicia as the bu	Physician/Medica									
Box	eath cer attendin for use	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		□Ectopic pregnanc	су		23d. Date of		
		sici	in the past 12 months? 1 ☐ Yes 21 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (specify)			Wildita	Day Tour	
Р. О.	The law requires that the de te has been signed by the a page 2 should be detached	Phy	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?	
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00	w req	Completed						24a. Was	an 24b. We	ere autopsy findings available	
e T	The lav cate has page 2:	dmc							rmed? dea	or to completion of cause of ath? Yes 2 No	
		Be C	25. Was case referred to medical				26. Place of Dea	th (Check only o		Tres Zu No	
	Physiclan: this certificatal director, I	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		SIK SU BOA	her: 4 \sum Nursing H	ome 5 Resi	dence 6 □Other	(Specify)	
Division or	Attending Physician: r death. ector: After this certifics by the funeral director, I		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Wo		28d. Describe	how injury occurred		
<u> </u>	ttendi leath. ttor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	e 280 Place of ini	ary - At home, farm, s]Yes 2□No	28f Location /	Street and Number	or Rural Route Number,	
≥ .	or Al after of Direct In by	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	areet, factory, office		City or To		or nural noute number,	
	spital			hysician: To the best							
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	miner: On the basis o and manner st		investigation, in my	opinion, death occu	rred at the time,	date and place, an	d due to the cause(s)	
	To the within To the Comp	Ž	29b. Signature and title of certifier	0 ,			se number		29d. Date signed (
			1 Janon Sta)	Doge	51199			.2009	
	15		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	e, Print)	Cuto 41	05 70	ا مادى	4021204	
	Sta	te	31. Date-filed-Menth-DaveNers	32. Registr	s Signatura	م ا لدون	00110 11			7 0	
	Registi		31. Dat 0 C 1 M 0 16 2009	cerem ,	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician ENN19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4o. County of Death **Examiner** BALTIMORE MAPLE AVENUE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 46 Director 213-86-1754 JUNE Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director BALTIMORE MARYLAND 10g, Citizen of What Country? 10e, Street and Number Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married 1 ∐Yes 2 KZ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes, Give þ Specify: BLACK 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) TRASH REMOVAL 9TH GRADE if Health and Mental Hyginitem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PEOPLES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHNISON (SISTER) 7319 BERKSHIRE Date 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of permit. Pages 1 Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL HOME + CREMAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JR. FUNERAL HOME MILLOWD 2140 N. FULTON AVE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence vi): 3 month /Medical Examiner acounted 48458 Minuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (Ir as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician a for use as the burial-t Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 | Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 1 Yes 2 MNo 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

B Zimin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Greene St

32. Resistrar's Signature

29c. License number

BoHimore

D3963

an

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 102 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year ROBERT WILSON PARK JR 4:08 A OCTOBER 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center @ GBMC Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** (Month, Day, 1 ₺ M 2 🗆 F Months Days Hours Min **Director** 229-40-5554 Yrs 936 Virginia Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford 1 Yes 2 X No Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 443 Haslett Road 21085 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumants. 4 Salesman Business Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Wilson Park Sr Adele Gertrude Herlihy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 443 Haslett Road, Joppa, Barbara J. Park Maryland 21085 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Gremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify) from State <u>Darlington Cemetry</u> 10-9-09 Darlington, Maryland 21. Sign Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Fart 1. Enter th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ His he mers demont disease or condition resulting in death) year Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specity) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, orten 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗆 No 1 Tes or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: 2 X No Other: 1 🗌 Yes ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA is 200-1. In 24 hours after deau... The Funeral Director; After the related filled in by the funera 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Testifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2

Box 68760

P.O.

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signatyre and title of certifier

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ist 2009 03:37AM moder 19m /Medical County of Death 4a Facility Name (If not institution, give street and number Town, or Location of Death Examiner BAHMORE BURN Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 MM 2□ F Months Hours Min. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show and 2 should be filed within 72 hours after death with the Maryla feath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f shov her traumatic event, the Medical Exanditiver must be notified at HANGVER 1XYes 2□No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Count Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ★No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates: 1 ☐Yes 2 No þ Specify. 3₫Widowed 4□Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMOSTIC ENGINEER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If it any Injury or concept 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Superal Service Licens 11. MD 20794 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) etastatic Physician years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed tooks after death.

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4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 Other (specify) 9 I Inknown 9 Unknown er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2.21No tens 1000 1 ☐ Yes 1 ☐ Yes Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number ss of person who completed cause of death (Item 23a) (Type,,Print) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 5 35 AM **Physician** Kenade Paige October 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Care - Lochean If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 X F 62 MD Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County nem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore 1XYes 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Oak Avenue 5013 GW nn USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: Rack 3altimore, Marylahd 21215-6036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)_ ementary/Secondary (0-12) College (1-4or 5+) ecial Baltimore City School Laucator 2th grade 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lumes W. Hacaes 4naela 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James William Paige Baltimore MD 21207 Dak Alenue Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Glen Burnio, MD ò 07 109 101 injury Veughn C. Greene Funeral Sonies 21. Signature of Funeral Service Licenses Road Handallstown, MD 2033 Approximate Interval Between Onset and Death 23a. Part1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, shock, or he vt failure. List only one cause on ach in . Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Tue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transi Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier 00043375 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEISTERSTOWN, UN 21136 KATLEN W. MERLITT 25 MAIN STREET 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT 0 6 **200**9

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Phys		1. Decedent's Name (First, Middle	PETTIE			2. Date of D Month	Day Yea			
	dical niner	4a. Facility Name (If not institution		4b. C	ity, Town, or Locatio		4c. County of De	-		
			MOTON HEDICA		der 1 Year If Und	NE er 24 Hrs. 8. Date of E	A HHA			
Funer Directo	_	217-40-5757	6. Sex 7. Age (<i>In yrs</i> . 1 ☐ M 2 P F	Mont			9/1942 9. B	irthplace (State or Foreign Country) Maryland		
Maryland a-f show		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits		
	ctor	MD Anne	Arundel		Glen Bur	nie		1 □Yes 2 ☑ No		
or 28	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of What Country?			
sath w	eral	108 Inglewood	od Drive 12. Was Decedent Everin U	6 13 Was Do	2106		U.S	• A • nerican Indian,		
ary idning Z I Z I 3-UU30 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Individed they flan "hatural", or items 23a or 28a-f show amarked other than "hatural", or items 23a or 28a-f show umatic event, its Moderal Event in a the bond flank at	by Funeral Director		Armed Forces?		pecify Cuban, Mexic	Origin? (Specify Yes or N can, Puerto Rican, etc.) ify:	Specify:			
72 ho	eted	15. Decedent (Specify only highes	's Education t grade completed)	16a. Decedent's U	Isual Occupation work done during m Tuse retired)	ost of working	16b. Kind of Busines	ss/Industry		
Z I Z I 3-UUSO d within 72 hours aff giene. or than "natural", or	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				0			
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/ I'all uld be Wenta irked itic ev	70 B	Melvin	Link			Hilda M	arie Sadl	er		
~ ~ ~ ~		19a. Informant's Name/Relationsh		19b. Mailing Addr	ess (Street and Nun	nber or Rural Route Num	ber, City or Town, State	e, Zip Code)		
		Wayne Pettie		108 In		Drive, Gl	en Burnie	MD 21060		
SAILLIMORE , sermit. Pages 1 ar Department of Hea Important: If item any Injury or other		1 Burial 2 ☐ Cremation	3 ☐ Removal from State	cemetery, crematory o	or other place)		,			
IIIIII artme ortani Injun	oj l	4 □ Donation 5 □ Other (Sp. 21. Signature of □ meral Service L	1110	oly Cross	Cem and Address of Fac	10/05/09	Baltimo	re, MD 1 Home, PA		
Dallillio permit. Page: Department o Important: If any Injury or once.	Sign	1/1/5		169	Riviera	Drive, P	asadena,	MD 21122		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
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/Medica		resulting in death)	Due to (or es e conseq	I HOME WAS TO A TO	>			LOYEARS		
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icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
oo rou, ificate be e g physician is the burial	ğ		d							
£ 5 10	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23d. Date of o	delivery Day Year					
that the d ed by the detached	hysi	1 □Yes 2 🗖 No 9 □ Unknown	4 ☐ Pregnant et time of e	death 5 ☐ Other	(500011)					
ecords, P.O. BOX law requires that the death cel as been signed by the attendir 2 should be detached for use	ā	Tark it. Other significant containons commutating to death but not resulting in the underlying cause given in Part i.						d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 🔀 Unknown		
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OI VILA Physician: r this certific ral director, I	10	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	Nursing Home 5 ☐ Re	Home 5 ☐ Residence 6 ☐ Other (Specify)					
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	be how injury occurred							
	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	M 1 □Yes 2 □No ome, farm, street, factory, office 28f. Location City or To			n (Street and Number or Rural Route Number, Town, State)				
e Hospita 124 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)								
To th To th comp	Me	29b. Signature and title of certifier	29c, License number			29d. Date signed (Month, Day, Year)				
		> Oniopunas	D0065£1A			SEPTEMBER 29, 2009				
		30. Name and address of person v	vho completed cause of death (Iter		lass sales	· Cleur.	wie han	0161		
5	State	31. Date filed (Month, Day, Year)				E, GLEN BUR	This WD T	1010		
Regis		OCT 062	32. Registrar's Signa	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 08/0 **Physician** UHINDI 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis 1701 Wells Street If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Dec 31, 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Year 1 M 2□F Months Days Hours 1933 Uganda 216-25-2532 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2% and other traumatic event. The processing of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of the standard of th 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 No Director Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21.401 1701 Wells Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk ပ Unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 406 AptC Captains Circle Annapolis, Maryland 21401 Soohia Ruhindi, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/06/09 Baltimore, Maryland Metro Crematory Inc. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor ²² Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 homas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. | eral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐Yes 2 No SAMUR ANNAPULY 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined 4 Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 29c. License number 29b. Signature and title of certifier ocompleted cause of death (Item 23a) (Type, Print Name and address of person y Aegistrar's Signature 31. Date filed (Month, Day, Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **C** Month Physician/ Ruhmann Jr cotember Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death = ASTON 5. Social Security Number 7. Age (In yrs. last birthday) 69 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 9, 1939 **Funeral** Days 1 X M 2 - F Months Hours Min 013-30-8703 Director Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel Pasadena RUHMAN 10e. Street and Numbe 10f. Zip Code Funeral 203 Sharon Drive 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give δ 1 Never Married 2X Married カントゥ M KUH/ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 2 Bruno Ruhann permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Mrs Annette Ruhmann/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of October 2, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2009 Atlantic Crematory Signal of Fun al Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Non-Hodgkinis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
b Hours after death.
certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes funeral director, page 2 should 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🔀 ၉ 1 Tes 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at (Month, Day, Year) injury 1 Natural 5 Pending ħΛ 1 Yes 2 No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier within 2 To the F 29b. Signature and title of certific 29c. License number

3. Time of Death 4c. County of Death 9. Birthplace (State or Foreign Country)
Boston, MA 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Rusiness Industry Defense Contractor 18. Mother's Name (First, Middle, Maiden Surname) Angeline Ruth Croteau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Sharon Drive Pasadena MD 21122 20c. Location - City or Town, State Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Serivore PA 1 2nd SW Ave. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI) veson TRAL 31. Date filed (Month, Day, Year) 32. Registrar's Sig State Registrar 6

			1 - For State Registrar		State of Ma	aryland		artment of I <i>rtificate of</i>		Mental		ene . No.		- 1-1-6-2-7
I	Physici /Medic		1. Decedent's Name VICTOR FREDE		ast)						of Death h er 3,	2009	Year	3. Time of Death 6:08P M
Examiner			4a. Facility Name (If not institution, give street and number) Laurel Regional General Hospital					4b. City, Town, o	or Location of Dea			4c. County Prince		es
	Funeral Director		5. Social Security No. 216–20–3908		Sex 7. Ag		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Mir	s. 8. Date (Mon March	of Birth th. Day, 19	25	9. Birthp Cour Maryla	place (State or Foreign htry) BINC
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	the N	irect	Maryland 10e. Street and Nun	Baltimore nber		Bait	imore	10f. Zip Code			10g	. Citizen of \	What Coun	1 ☐ Yes 2 XXNo
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	ours after dea ral", or items Examiner m	by Funeral Directo	11. Marital Status 1 ☐ Never Marrie 3 ☒️ Widowed	ed 2 Married	12. Was Decedent B Armed Forces? 1 M Yes 2 In If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub I □Yes 💥 No	Hispanic Origin? (an, Mexican, Pue Specify:	Specify Yes rto Rican, etc	or No-		e - Americ ck, White, e v: Whi	etc.
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	ed d		17. Father's Name (First, Middle, Las. Victor Roy					18. Mother's Na Marie K	,		^{iden Surnan} leri ck	ne)	
	12 s thai		19a. Informant's Na			Son	I	ng Address (Street						,
	tem 2				Removal from State	20b. Pla	ace of Dispo	Dalesfor	i	Date		c. Location -		
Baltimore,	t. Pages tment of tant: If ik ijury or o		1 ☐ Burial 2 Ø 4 ☐ Donation	oremation 3 ☐ 5 ☐ Other (Speci	Removal from State	Gree	enMoun	natory or other pla t Cremat	ory Oct	7, 200	9 B	altimo	re, i	Maryland
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Fu	1 12/	pisee RWSON		22		ess of Fa∰ti⁄tC York Ro					al Home Inc nd 21212
S/6U, cate be executed Examine physician and the burial-transit	Physician /Medical Examiner		Immediate Cause (idisease or condition resulting in death)	Final	olications that caused one cause on each lin a. My OCar Due to (or as a	dial_	Infar		ng, such as cardia	ac or respirat	ory arrest		6	Approximate Interval Between Onset and Death
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V 113	iclan: certific ector,		25. Was case referre		Hospital:			1044	26. Place of De	ath (Check o	only one)			
DIVISION OF VIEW To the Hospital or Attending Physician: within 24 hours after death.	Phys this aldi	ion: To	27. Manner of Death 1 Shatural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work?							ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred				
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DHMH 17 Rev 1/2001

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amend #30 Per Dvgt 6896 10/06/09 Denartment of Health and Mental Hygiene

		ertificate of Death	Reg. No.	3 3 9 3					
hysician /Medical	1. Decedent's Name (First, Middle, Last) Doris E. Ritchie		2. Date of Death Month Day September 29, 200	3. Time of Death 7:00 PM M					
Examiner uneral	4a. Facility Name (If not institution, give street and number) Frostburg Village Nursing Home 5. Social Security Number 1.	Months Days Hours Min.	4c. County of De A11e (A11e (Month, Day, Year) 9. E						
rector	Usual Residence of Decedent			cyland 10d. Inside City Limits					
marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examinant matic event, the Medical Examinant must be rediffed at To Be Completed by Funeral Director									
or 28a-f s	MD Allegany Fros	10f. Zip Code	10g. Citizen of What (1 □Yes 2√□No Country?					
ust b	67 Grant Street	21532	USA						
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event,	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	gy					
2	Ismael Filer	Alice	Porter						
Δ_		iling Address <i>(Street and Number or Run</i> O Southampton Brid							
- 1			Date 20c. Location - City of						
once.	21. Signat re of the Licensee Ronald 5. White Virector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201								
edical Examiner	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, for heart failure. List only one cause on each line. Immediate Cause (Final disease or con fillion resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
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Be (25. Was case referred to medical examiner?		(Check only one)						
ation: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	of 28c. Injury at	g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred						
Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		Rural Route Number,						
Medical Certification; To Be Com	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
Me	29b. Signature and title of certifier **Machine Transfer of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Contr	29c. License number 26907	29d. Date signed (Mo	nth, Day, Year)					
State	30. Name and address of person who completed cause of death (Item 23a) (Typ Harjit S. Sidhu Frostburg Vill 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Cumberland,MD 21	502					

09-07686					
Marilyn Rathert					

larilyn Rathert	State of Maryland / Department of Health and 1- For State Registrar Certificate of Death	Mental Hygiene Reg. No.		
Physician Medical Examina	Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year October 3, 2009 3. Time of Death 0837 hrs		
	4a. Facility Name (if not institution, give street and number) Northwest Hospital Center 4b. City, Town, or Lo Randallstown	cation of Death 4c. County of Death		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min. July 22,1963 Country) Texas		
	Usual Residence of Decedent	10d. Inside City Limits		
Varyland 288-f show any 1 at once	N=	1 Yes XX No		
th the Maryland 23a or 28a-f sho notified at once	10e. Street and Number 10f. Zip Code 4711 Riverstone Dr. Apt. 204 2	10g. Citizen of What Country? 1117 U.S.A.		
r death with the or items 23a must be noti		nic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.		
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215-0036 be filed within 72 houndfall Hygiene. rked other than "nattent, the Medical Example And Programment, the Medical Example And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programment And Programm	7 Certified Nurs 17. Father's Name (First, Middle, Last) 18	ses Assistant Health Care Mother's Name (First, Middle, Maiden Surname)		
21218 ould be fill d Mental H s marked it event, I	James Oliver Williams, Sr.	Junita (Williams) and Number or Rural Route Number, City or Town, State, Zip Code 1117		
MD 3 shot alth and 1 is m 27 is 1		tone Dr. Apt. 204 Owings Mills, M		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Realth and Mental Hygiene. Important: If iten 27 is marked other than import or other traumatic event, the Medical To Be Commodia	1 Burial 2XX Cremation 3 Removal from State crematory or other place)	Inc. 10/06/09 Baltimore, MD		
Baltir permit. E Departme Importar injury or	21. Signature of Fundal Squite Licensee 22. Name and Address of	FacilitiEckhardt Funeral Chapel P.A.		
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To the He within 24 To the Fu complete)	29b. Signature and title of certifier 29c. License r			
10	Theodre W. King Try mi). O.C.M.	October 4, 2009		
Ψ	A	et, Baltimore, MD 21201		
State Registra	31. Date filed (Month, Day, Year) 2000 32. Registrar's Signature			

			For State Registrar	State of Ma	aryland		artment of F ctificate of			giene Reg. No.	7 9	0:031
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	th wit	rai D	2 Meadowwood					92656		USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Eroniner mut be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 □Yes 25□ N If Yes, Give Year or Dates:		'	Nas Decedent of H fYes, specify Cub I □Yes 2 █\No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)		America White, e	tc.
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			30. Name and address of person who	. h	eath (Item 2			. (1)	2 4	A.II C	~7:-	761
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh 8896 10.6.09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Vear 10 : 20 PM Keith D. Shortridge, Jr. OCT 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE HOSPITAL AGNES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1948 | 9. Birthplace (State or Foreign Country) | 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Months 1 **X**M 2 ☐ F Yrs. 121-38-0486 61 Nov. 6, 1947 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Maryland Baltimore Gwynn Oak 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 5938 Prince George Street United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 □Yes 2X No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Program Director Correctional System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Keith D. Shortridge, Sr. Inez Carty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karim Shortridge/ Son 7161 Masters Road, New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 5. 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee Amanda Heaston 301 Frederick Road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PHEUMONIA weeks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) □Yes 2□No a∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHF 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 MNo 24a. Was an autopsy performed 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29d. Date signed (Month, Day, Year)

2009

permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any injury or other traun once. **Physician** /Medical Examiner led by the attending physician and detached for use as the burial-tran P.O. Box Division of Vital Records, the funeral

RIDGE

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Exerciper must be notified at

Funeral Director

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Certification:

Medical

(Check only

29b. Signature and title of certifler

31. Date filed (Month, Day, Year)

with the Maryland

State Registrar DHMH 17 Rev 1/2001

ALWAFAA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHATIB

Registrar's Signature A parked

M.D.

P24062

HOSPITAL

ST. AGMES

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year 15:59P M October Kathy Lyn Stevens 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Co. Baltimore Washington Med. Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 065-40-5198 64 New York 10/09/1944 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Glen Burnie Maryland | Anne Arundel Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 127 Glen Road United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 ∏No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Work Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Anne Arundel Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. Kaplan Anne Kahn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Mr. David A. Kaplan / Son</u> 740 N.E. 10th Place Gainesville, FL 32601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Cemetery 10/06/2009 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Bervices PA; 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 ocardia mmed. or as a consequence of Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐No 6 Could not be determined

law requires that the death certificate be executed burial-tra P.O. Box 68760, attending physician for use as the buris ed by the detached if signed I Division of Vital Records, page 2 should peen has certificate funeral After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

completely filled in by the

Physician/Medical

2

Completed

Be

Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Physician

Examiner

Funeral

Director

28a-f show is 23a or 28a-f shov

items 23a

o,

"natural", er than "natura" . the Medical E

7 is marked other traumatic event,

permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is mark any injury or other traumati once.

Physician

/Medicai

Examiner

Director

by Funeral

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar's Signature

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

1209A Marda Nancy D Rivera-King

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

n-, Annapodis, MD

31. Date filed (Month, Day, Year).

			State of Maryla State of Maryla For State of Maryla		rtment of Health and tificate of Death		ene g. No. 2009	3193
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Vear	3. Time of Death
н	Physicia /Medic		JOHN SCOTT SAGER			0ctober	3, 2009	8:00A M
4	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	eath	4c. County of Death	
, de			692 Gladstone Avenue		Baltimore If Under 1 Year If Under 24 F	re 9 Date of Pirth	None	place (State or Foreigr
	Funeral Director		218–78–8140 XX ^{M 2□ F} 5	ors. last birthday).	Months Days Hours M		1959 Mary	ntry)
-	and w		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Loc	cation			10d. Inside City Limits
	Maryla f sho	to	Maryalnd None Ba	ltimore				X1X Yes 2 No
	the 7	Director	10e. Street and Number	10111010	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	3a ol		692 Gladstone Avenue		21210		USA	
	death	Funeral	11. Marital Status 12. Was Decedent Ever i	n U.S. 13.	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Amer Black, White,	
21215-0036	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show Inatural Evandarian out be maiffied at	ρ	1 ∩ Never Married 2 Married 1 ∩ Never Married 2 Married 3 ∩ Widowed 4 ∩ Divorced Armed Forces? No If Yes, Give Year or Dates:		1 □Yes 2 X No Specify:			nite
5-0	72 hc	etec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of		16b. Kind of Business/li	ndustry
121	within iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired) ISE Removal		0wner	
2	filed within Hygiene. other than ' ent, the 'm'		17. Father's Name (First, Middle, Last)	INC F		Name (First, Middle, N		
an	Mental arked or	To Be	William Aaron Sager		Nin	a Bubert		
Maryland	sho and Ism	F	19a. Informant's Name/Relationship (Type. Print) Julie Harrison Sager Wif	e 692 (ng Address (Street and Number of Gladstone Avenue	Rural Route Number, Baltimore	City or Town, State, Z., Maryland	^{ip Code)} 21210
	Health tem 27 other tr		20a. Method of Disposition	b. Place of Dispo	sition (Name of matory or other place)	Date	20c. Location - City or 1	own, State
mo	Pages ent of nt: If I		1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	reenMour	nt Crematory Oct	6, 2009 B	Baltimore,	Maryland
Baltimore,	permit. Pages 1 Department of F Important: If Ite any injury or ot		21, Signature of Funeral Service Licensee	RIA	2. Name and Address of Fac My †	chell-Wied	lefeld Fune	ral Home I
			23a. Part 1. Enter the disease or complications that caused the	death. Do not en	ter the mode of dying, such as car	diac or respiratory arro	est,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	'a consult	rbesophageal.	adenorare	inoma	Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a cor	sequence of):	300	00010		
	Examiner		h					
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	sequence of):				
	ecute ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor	and the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second o				
, 0,	e exectan a	ű	resulting in death) Last Due to (or as a cor	isequence of):				
8760	cate to	dical	d					
. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day Year
P.O.	w requires that the despensions that the should be detached	hys	9 Li Unknown			220 Did to	bacco use contribute to	the cause of death?
	es the	è.	Part II. Other significant conditions contributing to death but no	t resulting in the u	inderlying cause given in Part I.	1 XY		obably 4 Unknow
Records,	equir Ben s ould	ted						
Ö	elawr hasb e2sh	Completed				24a. Was a autops	n 24b. Were au sy prior to med? death?	itopsy findings availab completion of cause of
= H	the cate h	Son					2 XNo 1 □ Yes	2 □ No
Vita	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?		Other:	Death (Check only or		
of	Phys this al dir	2	1 res 2 No 1 Inpatient	2 ER/Outpatie	III 3 DOA 4 Nursi	3	ence 6 Other (Spe ow injury occurred	cify)
UC	ding I. After funer	tion	1 Natural 5 □ Pending (Month, Day, Ye	ar) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No			
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	21 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - building, etc. (S	At home, farm, st pecify)			itreet and Number or R n, State)	ural Route Number,
	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of m 2 Medical Examiner: On the basis of exe and manner stated.	y knowledge, dea amination and/or i	th occurred at the time, date and nvestigation, in my opinion, death	place, and due to the occurred at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	ithin (Mec	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)
_	F ≥ F ŏ		M.D.		200693	29	Ort 5 2	009

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 R 2009

2. Registrar's Signature

A. Sauce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mei Tang, MD 6569 North Charles St, Swite 265,

DHMH 17 Rev 1/2001

	1 - For State Registrar	State of N	/larylan		artmen ertificate					giene	09		33
ian	1. Decedent's Name (First, Middle, La								2. Date of Dea		ŏ°3'	3. Time of E	
ical	Amin	Sharif			1 41 01	F	Location	- (D 4 h	10 2	2 20 4c. County		0530) м
iner	4a. Facility Name (If not institution, gi Season's Hos		er)				alls		1	Balt			
		As	Age (In yrs.	last birthday) If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	h	9. Birth	place (State or	Foreign
	216-54-6033	Ж ЖМ 2□ F	59	Yrs.	Months	Days	Hours	Min.	1 26	5 Year) 5 1950	Cou	intry) MI)
	Usual Residence of Decedent 10a, State 10b, County		100 CH	ty, Town or L	costion							10d. Inside City	Limite
ō		/A		Balti								1 X Yes	
Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of W	/hat Cou	ntry?	
Ö	1439 Limit A	vanue 1	Apt.	K		1239	Э			USA		,	
Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.		. Was Deced	ent of Hi	spanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	14. Race		ican Indian,	
Y Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give			1 □ Yes 2		Specify.		riioan, cio.,		k, White,	ack	
od by	3 ☐ Widowed 4 🔀 Divorced	Year or Dates	3:	I don Don									
Completed	15. Decedent's E (Specify only highest gi	rade completed)		i (Giv	edent's Usua e kind of wor DO NOT us	k done d	luring mos	st of worki	ng	16b. Kind of Bu	siness/ir	idustry	
E	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Worl	c Rel	easé	e Co	unse	elor	Dept.	of	Corre	ctio
Be C	17. Father's Name (First, Middle, Las						18. Moth	er's Name	(First, Middle,	Maiden Surnam	e)	•	
ည	Ulysses	Bagwell	L				Io	la		White			
To Be Completed by Funeral Director	19a. Informant's Name/Relationship	(Type. Print)			•	•				er, City or Town,		· _ ·	
	Iola Bagwell-	mother	l ook r				Road		Ltimor		2122		
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [1 0	Place of Disp cemetery, cre . ng Me	matory or or	her place	e) Dark)ate /3/09	20c. Location -	-		MD
	4 Donation 5 Other (Spec		KI		22. Name an		1	. .					
	21. Signature of Funeral Service Lice	Jarch						MAH	RCH FU	NERAL E Baltimo	HOME	E-EAST	1202
	23a. Part 1. Enter the disease, or cor	nplications that caus	ed the deat									Approximate	
	shock, or heart failure. List only Immediate Cause (Final			ESOF	haran	1 1	11 0/	00				Interval Betw Onset and D	
	disease or condition resulting in death)	a	as a conseq		The oje a	C C	wite						
	Cognentially list conditions	b											
Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	tience of):							51		
xam	Cause (Disease or Injury that initiated events resulting in death) Last	C	as a conseq	uonco of):							-		
a E		Due 10 (0) 8	as a conseq	derice oi).									
edical		d											
n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon								23d. Dat	e of deliv	very	
Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnan	t at time of o		□ Ectopic p □ Other (sp		<i>'</i>			Mo	nth	Day Y	ear
hys	9 ☐ Unknown	9 ☐ Unknowi	1										
by F	Part II. Other significant conditions	contributing to death	but not res	ulting in the	underlying ca	ause give	en in Part i	l.		obacco use contr		/	
									1 🗆 \	res 2 □ No	3 ☐ Pro	bably 4 0	nknown
ompleted									24a. Was autop	sy / r	prior to co	opsy findings a ompletion of ca	vailable use of
S											leath? □Yes	2 🗆 No	
Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place	e of Death	(Check only o	ne)	n-Pa	tient has	DI (+
2	1 Yes 2 No	1 ☐ Inpa	-	ER/Outpatie		8c. Injury	`` 4 🗀 N ⁄at	ursing Ho	me 5 Resident	tence 6 Toth	er (<i>Spec</i>	ify)	
tion	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, I	Day, Year)	Injury	M	Work	? Yes 2 🗖		_54. 200011061	jury occurr			
ertification:	3 Suicide 6 Could not 8	be 28e. Place of	njury - At ho	ome, farm, s	treet, factory	office	192017	1		Street and Numb	er or Rui	ral Route Numb	per,
Cert	4 Li Homicide	bullding,	etc.*(Specif	y)					City or Tov	vn, State)			
	29a. Certifier 1 Certifying P	Physician: To the be aminer: On the basis	st of my kno	wledge, dea	th occurred	at the tin	ne, date a	nd place,	and due to the	cause(s) and ma	anner as	stated.	
Medical	one)	and manner											
2	29b. Signature and title of certifier Rupanul	M.D			290	. License	number	-		29d. Date signed	(Month	, Day, Year)	
		1-1-12					0003	741	65	10/2 DWN, M	-/0"	1	
	30. Name and address of person who	completed cause o	t death (Iten	n 23a) (Type 1 <i>a</i> (1)	Print)	e 7	200	, Re	isterste	OWN, M.	D.	21136	
ate	31. Date filed (Month, Day, Year)	32. Regin	strar's Signa	iture @	2	0 0		/					
ate	51. Date filed (brothin, Day, Year)	32. Hegh	onars Signa	uure A	Maria as	2 8							

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760代シ

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Physician Sawyer 10:19a M Stephen Marcus October 5, 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Summit Park Nursing Home Catonsville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours XXM 2□ F 564-50-2419 68 CA Director 03/04/1941 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural"; or items 23a or 28a-f show traumatic event, the "Addon Examiner must be notified at TX Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21229 1234 Pine Heights Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or increasing injury or other traumatic event when the page. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1

 Yes 2

 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ XNo Specify: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacture Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oris William Sawyer Mary Jane Marcus မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 Fifth Ave. , Baltimore, MD 21227 Sawyer / Wife Anna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/6/2009 Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Seervices PO Box 1413, Baltimore, MD 2 21. Signature of Funeral Service Licensee Dorota Marshall M. MUWSHan 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SCHEMIC CARDIOM TOPATHT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Attending Physician: The law requires that the death certificate be executed RENAL HOUNIC attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical DI MOSE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2X No certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö Hospital 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) ature and title of certifier 29b. Sign PRINARY CARE D0016948 October 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Armory Place Suite 3H Baltimore, 21201 M.D Tansinda (Month, Day, Year) 32 Registrar's Signature State OCT 0 6 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Rea, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SEPTEMBER 30, 2009 **Physician** 5:45F M ELLA MAY SPARR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 01/09/1915 **Director** Maryland 215-03-2066 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Show The Medical Examinar must be notified at 1 ☐Yes 2 No Director MD Baltimore Glen Arm or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a Completed by Funeral 12040 Long Green Pike U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fand Mental I other traumatic ပ John Walter Anthony Katherine Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Joseph Kempske 11748 Harford Road - Glen Arm, Maryland 21057 (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 10/03/2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. assahn 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** ACUTE CONGESTIVE HEART FAILURE DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit DAYS RIGHT LOWER LOBE PNEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Dav 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certified D25886 30. Name and address of person who completed cause / death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

gistrar's Signature

OSLER DRIVE TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26perPHYS, G896, 1076/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 02, Month **Physician** Scott Harry 11:10P M Oct. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA. 238 N. Payson Street Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2 F MD 214-56-6837 60 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, Ite Medical Examination and be redified at XX Yes 2□No Baltimore MD NA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21223 Funeral 238 N. Payson Street 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.African 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify SpecifyAmerican þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 2 V T S . (1-4or 5+) Hardware Store permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 is marked other tha any injury or other traumatic event, If an once. Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willa M. Herring Harry M. Scott, II 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Collette Y. Carter N. Payson Street Baltimore, MD 21223 238 20a. Method of Disposition
14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State Date 10-08-09 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 nee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATOCELLULAR CA OF LIVER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to for as a consequence off if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed and physician ar s the burial-tr Due to (or as a consequence of): Box 68760 Physician/Medical led by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed rhosis OF LIVER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an autopsy performed? Δ certificate He 1 □Yes 2 KNo Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6-Bother (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After this funeral c To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar AM

31. Date filed (Month, Day, Year)

OCT 0 6 2009

30. Name and address of person who completed cause of Leath (Item 23a) (Type, Print)

32. Registrari Signat

Scott

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day Year 9 **Physician** Summers 30, ${\tt Trudell}$ 9:30P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NA Future Care Homewood Baltimore 8. Date of Birth Month, Day, 11-10- Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 📈 F Months Days Hours Min. GA 260-64-6466 66 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Event increment be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State YYes 2 □ No Baltimore **Funeral Director** NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21217 2126 Brunt Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. African 1 Never Married 2 Married 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: Completed by Specify: American 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Elementary/Secondary (0-12) 12th Grade 1 V T • (1-4or 5+) Dermatalogist Maryland Unk. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Butler Ruby မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seamon Avenue Baltimore, MD 21225 3029 Yvonne Crosby 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 10-03-09 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses Street Baltimore, MD 21217 638 N. Gilmor Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ASCUD Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death 5 ☐ Other (specify). 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Many r of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 2 ∏No 1 ☐Yes 2 Accident investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier from Woods Rose ng completed cause of death (Item 23a) (Type Pri State

DHMH 17 Rev 1/2001

Registrar

OCT 0 6 2009

21215-0036

Baltimore, Maryland

Box 68760.

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Division of Vital Records,

			For Stete Registrar	State of N	Marylan	•	rtment of H		nd Mental Hy	giene	2009	31943
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			Good Samaritan Nurs				Baltimore	If Under 2	4 Hrs. 8. Date of B Min. 12/25/19		I/A	-lane /Gtota as Carrier
	Funeral Director		5. Social Security Number 6. 213-10-6046	Sex 1 M 2 X F 7. A	98 (In yrs.	last birthday) Yrs.	Months Days	Mary	place (State or Foreign ntry) .and			
		1	Usual Residence of Decedent		30				1,,			
	yland		10a. Slate 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Mar	ţ	MD N/A		Balt	imore						1 X Yes 2 No
	1.28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	h with		1019 Woodheights Av	venue			21211			U.S	S.A.	
	deat	Funeral	11. Marital Status	12. Was Deceder Armed Forces		.S. 13. \	Vas Decedent of Hi	spanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	0- 1	4. Race - Amen Black, White	
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21215-0036	72 hours after death with the Maryland "naturel", or Iteme 23a or 28e-1 ehow idjoal Examinat must be notified at	d by	3 X Widowed 4 ☐ Divorced	Year or Dates	s: 						W	hite
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Ġ,	Hea The		20a. Method of Disposition	<u> </u>	20b. P		sition (Name of natory or other place		Date	,	ation - City or T	own, State
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ᆵ	permit. Pag Department Important: Iny injury o		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic		Uak	Lawn Ce	Name and Address	∫ ¦ s of Facility	0/07/2009 Leonard J.	Dall G	Inc.	yrana
Ba	permit. Pag Department Important: I eny injury o		A landin	DE ROOM	.)				Baltimore, M			
			23a. Part1. Enter the disease, or co	molications that caus	ed the deat						1	Approximate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	line.	_	1	1	1			Interval Between Onset and Death
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Вох	eath certific attending pl	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Je			2	3d. Date of deliv	у өгу
	death e atte d for	Physician/Medical	in the past 12 months?	1□Live birth 4□Pregnant	at time of d		Ectopic pregnancy Other (specify)				Month	Day Year
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	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
of Vital Records,	w require been sig should b	Pa							10	Yes 2	No 3□Pro	bably 4 Whknown
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\geq	Physician: this certific ral director,	To B	examiner? 1 Tes 2 ViNo	Hospital:	itient 2	ER/Outpatien	t 3 DDA Othe	25	sing Home 5 ☐ Re		□Other (Spec	ıfv)
0			27. Manner of Death	28a. Date of In	njury Day Year)	28b. Time of Injury	28c. Injury Work	al	28d. Describe	how injury	occurred	
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Division	of or Attency after death	tit	3 Suicide 6 Could not	d 289. Place of I	Injury - At he		eet, factory, office			(Street and own, State)	Number or Rui	ral Route Number,
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	the the the the the the the the the the	Med	one)	and manner	stated.		29c. License	number	1 1	20d Date	signed (Month	Clay Vaar)
	or Final Final Fi	_	29b. Signature and title of certifier	ROTA	~A	11011	n D	306	61	10/	signed (Month	th 2009
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	21		30. Name and address of person wh	o completed cause o	death (Item	n 23a) (Type,	Balten	riele	· Md	-2	1239	
	Sta	to	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ature #	usuu.				•	
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09-07517	
John Snyder	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2, Date of Death **Medical Examiner** 1448 hrs September 26, 2009 JOHN DENNIS SNYDER 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Center Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Director Months Days Hours Country) 1**X**M 2 42 10/23/1966 219-82-9780 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Baltimore MD Arundel Director Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21226 .324 Cox Cove Court U.S.A. Funeral 11. Mantal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. Never Married Married Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 No specify. Specify: White ≥ or Dates:

15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sheet Metal Mechanic Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Snyder <u>Wayne</u> <u> Albert</u> Margaret Μ Paddy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, <u> Margaret Snyder / Mothe</u> Duvall Highway, MD 21122 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 2 Cremation 3 Removal from State crematory or other place) Burial Donation 5 Other Specify 10/01/09 ew Crematory Baltimore, 21. Signature Funeral Service Licensee 22. Name and Address of Facility G.J. Gonce Funeral Home, PA Drive. Pasadena, 23a. Part I. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Narcotic intoxication Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and Physician/Medical 23a, PII,27,28a-f per ME g896 10/30/09 TT X UNPENDED AMENDED the attending physician ed for use as the burial -Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) The law requires that the death 1 Yes 2 No 9 Unknown 9 Linknown detached Part II. Other significant conditions Records, P.O. Š contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signed ۾ Cocaine use 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of director, page 2 performed? death? ✓ Yes 2 No ✓ Yes 2 No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other, Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ۵ 1 ✔ Yes No 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural Yes 2 X No unk within 24 hours after death. Pending To the Funeral Director: completely filled in by the 9/25/09 Fd 1:45 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1324 COX COVE CT 3 6 X Could not be Suicide (Specify) house determined Curtis Bay, MD 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 27, 2009 ante. 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

31. Date filed (Month, Day, Year,

NGT 0 6 2009

32. Registrar's Signature

09-07651 Janet F. Sitzwohl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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				Pote of Birth (MA)	M/DD/YYYY) 9. Birt	onlace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.	o. Date of Birtin(Mi	Foreign	ו
Director		215-28-6937 1 M 2 X F 78 Yrs		Jan. 11,	1931 Col	ntryMaryland
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of H		1 X Burial 2 Cremation 3 Removal from State crematory or o	ther place)			
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Baltimore, MD 21215-00 permit. Pages I and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me	ĺ	21. Signatura of Funeral Service Licensee 22.	Name and Address of Facility KIRHLEY ~ DDICH	. H. P.A.		
ED 8 2 2 1 E		JAN SULL	Name and Address of Facility KIRHLEY AUDDICH 421 CRAIN HWY., 5	E GLEN BURN	IE, MD ZIC	261
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac of	or respiratory arrest, s	snock, or neart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. Hypertensive Atherosclerotic Card	diovascular Disease			Death
,xummor		or condition resulting in death) Due to (or as a consequence of):				
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	<u> <u>2</u></u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
9	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
No a se	Û	d				
760, crate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				
60, ate be	Nec	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	y
187 rtific ing p as th		23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregn	ancy	Month I	Day Year
Box 687; death certific	ici	4 Pregnant at time of death 5	Other (Specify)			
Bo e dea the a	Physician/	9 Olikilowii				
s, P.O. Box 687 irres that the death certiff is signed by the attending the detached for use as it		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?
sign lbe d	Completed by					
cords law requi has been 2 should	lete			24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
e law e has ge 2 s	m			performed 1 V Yes 2	d? death? No 1 ✓ Y	es 2 No
tal Reco cian: The law certificate has		25. Was case referred to medical	26.Place of Death (Check			
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been siled in by the functal director, page 2 should t	a	examiner? Hospital: 1 Innatient 2 FR/Outnaties	- loub est		sidence 6 🗸 Othe	r: Scene
of Ving Physical After this uneral dir	မ	1 V Yes 2 No Imparient 2 Erosuperson 27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		
n c ding h. Aft	Certification:	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
ivisior or Attend after death Director: I in by the	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, str	aet factory office building etc	28f Location (Street	et and Number or Ri	ural Route Number, City
Jivi I or after I Direction I	ij	3 Suicide 6 Could not be determined (Specify)	eet, lactory, office ballang, ctc.	or Town, State		
Spita hours nera	ပိ	4 Homicide		1		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	cal	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, an lation, in my opinion, death occurred	d due to the cause(s at the time, date and) and manner as sta I place, and due to ti	red. ne cause(s)
To the To the Comp	Medical	and manner stated.				
	Σ	29b Signature and tifle of certifier	29c. License number		9d. Date signed (Mo	
		//well Lator L/ cell	O.C.M.E.		October 2, 2009	·
Ve		3 Name and address of person who completed cause of death (Item 23a)				
Ψ		Victor Weedn MD JD Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201		/
	tate	31. Date file waith Pay Young 32. Registrar's Signature	1			
Regis	trar	O EUGO /OU				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Shock telen October 2009 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Manor Seminary Lutherville TVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕏 F 86 213-38-8937 June 22, 1923 Pennslyvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21013 5318 B. Patterson Road U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Susan Lesko Peter Parangosky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 5318 B. Patterson Road, Baldwin, Maryland 21013 John B. Shock Jr./ Husband 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/6/2009 Towson, Maryland Hilltop Service Corp. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) cars Due to (or es a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

ettending physician end for use as the burief-transit

hes

al or Attending Physicien: Ts effer death.
I Director: After this certificet ed in by the funeral director, pi

within 24 hours e To the Funerel C completely filled

The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Director

Funerai

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Completed

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Physician/Medical

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Completed

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Medical Certification:

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23e or 28e-f show any lainty or other treumetic event, the Medical Examinar must be multilled at once.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 5 Pending investigation

and manner stated.

2 ☐ ER/Outpetient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Assistal Living

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

1 🖾 Natural

2 Accident 3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s)

29b. Signature end title of-certifie

RCT 0 6 2009

6 Could not be

29c. License number

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Hlexande 31. Dete filed (Month, Day, Year)

State Registrar

		-	For State Registrar	State o	f Marylan	•	artment <i>tificate</i>				giene Reg. No.	009	31947
	Physicia		1. Decedent's Name (First, Middle, TOBY	Last)		S	ELIG			2. Date of Dea		200°3	3. Time of Death 7:58 A M
	Medic Examin		4a. Facility Name (if not institution, g	give street and num	nber)			own, or Loca	ation of Death	DOTOBER		ty of Death	17.50 N
			GILCHRIST HO	SPICE CA	RE			TOWSO			BA	LTIMOR	RE
2.00	Funeral Director		5. Social Security Number 112-26-3147	5. Sex 1 □ M 2 🗶 F	7. Age (In yrs. la 73	ast birthday) Yrs.	If Under 1 Months		Jnder 24 Hrs, ours Min.	8. Date of Birt		9. Birth Cour	place (State or Foreign ntry) NY
	tand show d at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Many 28a-1 notifie	Director	MD HOWAI	RD		COL	.UMBIA						1 🗆 Yes 2 🕭 No
	ith the	ral	10e. Street and Number	ODN UNV			10f. Zip 0				10g. Citizen o	f What Cou	ntry?
	ems armus	Funeral I	7472 WEATHER WO	12. Was Dece	edent Ever in U.S		Vas Deceder			cify Yes or No-	USA 14. B	ace - Americ	can Indian,
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 🗶 Widowed 4 ☐ Divorced	Armed Fo 1 Yes If Yes, Giv Year or Da	e No		f Yes, specify		exican, Puerto pecify:	Rican, etc.)		lack, White, ify: WHI	
5-0	2 hour "natur	Completed	15. Decedent (Specify only highes	's Education		16a. Deced	lent's Usual	Occupation done during	most of worki	ing	16b. Kind of	Business In	dustry
121	ithin 7; ene. • than the Me	Com	Elementary/Seconday (0-12)	College (1		life. Di	O NOT use n MEMAK	etired)		5	OM	N HOMI	-
d 2	be filed w ental Hygi ked other ic event, t	Be	17. Father's Name (First, Middle, La	1 '		1 110	WILLIAM)		Mother's Name	e (First, Middle,			
ylar	ild be file Mental iarked c atic eve	유	LOUIS		ZU	ICKER			BET	TY		ROTI	HNAGEL
Maryland 21215-0036	12 should Ith and M 27 is mar r traumati		19a. Informant's Name/Relationship MATTHEW SELIG							, #802			^{Code)} 20910 ING. MD
re,	of Health of Health fitem 27		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	of	1	Date	20c. Locatio		
im	Page ment c tant: If jury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		State COL	JMBIA N	MEMORI	AL PA	RK 10/0	5/2009	COLUM	BIA,_	MD
20a. Method of Disposition 1900 LTTIONSVILLE ROAD, #802 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signa re of Funeral Service icense 22. Name and Address of Facility 8900 REISTERSTOWN ROAD,										OL LEVI ROAD, P	NSON &	BROS.	., INC. MD 21208
			23a. Part 1. Enter the disease, or of shock, or heart failure. List on	ly one cause on ea	ich line.						rest,		Approximate Interval Between Onset and Death
71.74	Pnysician/ Medical	j Vi	Immediate Cause (Final disease or condition resulting in death)		n licat		f br	last	(anco			-	years
	Examiner			buc to	or a consequ	acride oi).							
	n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D. Due to	(or as a consequ	uence oi).							
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09	ate be executed physician and the burial-transit	dical	,	d									
	tificate ng phy as the	1 (D)	IF FEMALE:										
9 X C	it the death certifica I by the attending p stached for use as t	ian/	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	come of pregna Birth 2 Feta nant at time of c	aldeath 3	Ectopic pro					Date of deliv	very Day Year
<u>.</u>	he dea y the a iched t	hysic	1 ∐ Yes 2 Mo 9 □ Unknown	9 Unkr		Jean 5 L	J Other (spe	Ciry)					
Division of Vital Records, P.O. Box 687	v requires that t s been signed b s should be deta	Completed by Physician/M	Part II. Other significant condition	s contributing to d	leath but not res	ulting in the u	ınderlying ca	use given in	n Part I.				he cause of death?
ord	requii been should	lete								24a. Was		o. Were auto	ppsy findings available
Rec	sician: The law is certificate has k	Somp								autor perfo 1 \square Yes	osy ormed? 2 X No	prior to co death? 1 \square Yes	ompletion of cause of
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:					of Death (Check	(only one)		10500	ec a c
Ž	Physical this caral direction	<u>2</u>	1 ☐ Yes 2 No 27. Manner of Death	1	Inpatient 2 of injury	ER/Outpatier 28b. Time of		c. Injury at		me 5 Residence 128d. Describe h			e ilchnist
o uc	nding ath. r: After	icate	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestiga	(Mon	th, Day, Year)	injury	M	work? 1 ☐ Yes			ow injury cook		
ivisio	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place	of Injury - At hong, etc. (Specify		eet, factory,	office		28f. Location (S City or Tow		nber or Rura	l Route Number,
Ω ^	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical		Physician: To the base									ed. ause(s) and manner stated.
7	o the inthin 2 or the l	Ĭ		Nurse Practioner:	To the best of m	y knowledge, o		ed at the time		e, and due to th	e cause(s) and 29d. Date sign		
	-s-ō		Mari S	wt. CRNI	P		R	1491	14		Octob		
			30. Name and address of person w	ho completed caus	se of death (Item	23a) (Type, F	Print)	m	7 21	204			
	Sta	te	31. Date filed (Month, Day, Year)	32. R	legistrar's Signa	ture	w.		<u> </u>	φ - 1			
	Registra	ar	OCT 0 6 200	y coneg	a p.	19 550							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER 2009 RICHARD HOWARD TITTLE SR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1**X** M 2□ F Months Maryland Director 10-05-37 217-34-3567 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County show ral", or items 23a or 28a-f shov Evol, in a liver per polified at Director <u>Jarrettsville</u> Maryland Harford 10g. Citizen of What Country? 10e. Street and Number USA 21084 3846 Old Federal Hill Road Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: Specify: þ 3 Widowed 4 Divorced er than "nature", the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Gas & Electric Company 12 Foreman is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Franklin Tittle Sr. Mable Augusta Watters ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. 3846 Old Federal Hill Road, Jarrettsville, MD 21084 Shirley Lee Tittle / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Air Memorial Gdn | 10-6-09 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) palure of Euneral Service Licensee ²² Name and Address of Facility

McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart railers. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) roesophalea **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mg 1X inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10:30 AM

10d. Inside City Limits

Black

Approximate Interval Between Onset and Death

yeen

Year

One

Day

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 No

State Registrar 29b. Signature and

Myo Min (ILD.

29c. License number

Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAME AND AND SOUTH ALWOOD ROAD # 200, Bel Air, ND 21014

D45390

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

State

KeM

OCME

Laron Locke MD

31. Date filed

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) Margaret 2. Date of Death 3. Time of Death Mary, Month **Physician** 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore County 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) January 2 1916 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 🗌 M 215 05 1694 93 Baltimore, Maryland Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12230 Roundwood Road 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XX No Specify: \$ Specify: White 3x Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Housewife Housekeeping-Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Leroy Thillman Elonora Burgan ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland M. Vaeth Jr (Son) 2106 Lamar Court Fallston, Maryland 21047 imore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery October 7 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland at re of Funeral Service Name and Address of Facility
ASSAND FUNETAL Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NBMB **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Electrology, cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transi Due to (or as a consequence of): signed by the attending physician id be detached for 1180 as the build Division or Vital Records, P.O. Box 68760 be Physician/Medical IF FEMALE. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 100 1 Yes 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No certificate has autopsy perforn 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 1 🗌 Yes 2 ER/Outpatient 3 DOA P 1 Inpatient this 4**X** Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 Alvatural in 24 hours after where the Funeral Director: Af ∠ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print IEXAS 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

OCT 0 6 2009

32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 per fh 8896 10-6-09 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 6,20A M RON 2009 WILLIAM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NIA REHAB BALTIMORE 4 EXTENDED CARE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**⊘**M 2□F Days Hours 8 203 12 1484 NEW MEXICO Director EB 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits n and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Medical Extrail strongs to rediffed at 1 Yes 2 □ No Director MO CARROLL SYKESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 6134 USA ASIT GROVE COUNT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11√2 Yes 2 □ No 1943 -If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: þ Specify: WHITE 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE SALESMAN 17. Father's Name (First, Middle, Last)
Byron C. Wick 18. Mother's Name (First, Middle, Maiden Surname) Be PRANCES SIMCOX 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 21784 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. SYKES VILLE, MO AURA KAIN ASH NAUGHTER GROVE CT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State WINFIELD, MO 6/209 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZUMBRUN FH & MON Co. ELDERS BURG MD 21784 pol xumbrum SYFESVILLE 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** en ces disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) s been signed by the s 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has bodiector, page 2 st autopsy performed; 1∐Yes 2. XVo 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

6 2009

10 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs,	last birthday)	If Under 1 Y			8. Date of Bir		9. Birthplace (State or Foreign		
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Physician /Medical		failure. List only one cause	e on each line.							,,	Between Onset and Death		
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the temperal or the funeral director, page 2 should be detached for use as the temperal director.	Medical	(one only	aminer:On the basis and manners	of examination a									
FSFS	ž	29b. Signature and title of certif					nse number	OCME		29d. Date signed	(Month, Day, Year)		
		Theodor M. Kird TR., m. D. O.C.M.E. October 1, 2009								009			
,	ı	30. Name and address of perso											
9		Theodore M. King, Jr	- 11	ant Medical E		111 Penn S	otreet, Ba	itimore,	MD 21201				
Sta Registr	ite rar	31. Date filed (Month, Day Year 0CT 0 6 2009	Denova	egistrar Signat	arked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar amend #7&20b&c Per FH G896 10/15/09 for Death 2. Date of Death Month **Physician** X00 CHUL 30 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LAVREL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Months Days Hours 1**X** M 2□ F Douth KOROR Director of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State GREENBELT 10f. Zip Code 1 Yes 2 □ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? ZZ 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: HS/AX Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced Han-Chil 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS REUPHOLSHERER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be SUK YOU ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Nyme. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10/05/2009 Davidsonville, MD 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) FUNERAL HOMIC 21. Signature of Funeral Service Licenses or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition metastasis Cancer Years Physician resulting in death) /Medical Due to (or as a con e) ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner signed by the attending physician and be detached for use as the burial-trans The law requires that the death certificate be execute Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) I□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2\to No page 2 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Marmer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural Injury 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ted cause of death (Item 23a) (Type, Print) Ligan Rd, Ellicott City, MD 31. Date filed (Month, Day, Year) State Registrar

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4a,4b,4c,perPHYS,G896,10/14/09,WS
State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Eleanor Virginia Bunting 09 4c. County of Death rows, or Location of If Under 24 Hrs. Áge (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕏 F Months Davs Hours 215-12-6217 05/09/1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Worcester Pocomoke City 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 Dorchester Ave 21851 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) production worker printing company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Reid Virgie Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23349 Saxis Rd., Sanford, VA 23426 Ruth White/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/20/09 Remson U.M. Cemetery 4 □ Donation 5 □ Other (Specify) Pocomoke City, MD 21. Signature of Fyneral Service Licensee 22 Name and Address of Facility Home Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC DISPLASPE RUCTIVE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar

Physician

/Medical

Director

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Examiner

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?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at

"natural", or

is marked other

permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-003

the Maryland

Physician/Medical is certificate has been signed by the director, page 2 should be detached ò Be Completed Certification: To

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions cor	ntributing to death but not resulting	g in the underlying	cause given in Part I.	- No.		se contribute to the cause of death? No 3 Probably 4 Unknown		
					opsy formed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 → No		
25. Was case referred to medical examiner?			26. Place of Dea	th (Check only	one)			
1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 🗆 🗆	OOA Other: 4 Nursing H	lome 5 Res	sidence 6	Ofther (Specify) HOSPICE		
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, facto	28f. Location City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying Phys (Check only, 2 Medical Examinone)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death occurre and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to thurred at the time	e cause(s) e, date and	and manner as stated. place, and due to the cause(s)		
29b. Signature and title of certifier		29	9c. License number		29d. Date	e signed (Month, Day, Year)		

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To the I within 2.

State

Medical

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31. Date filed (Month, Day,

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WATHS

Year)

SEP 2 2 2009

0058410

29d. Date signed (Month, Day, Year)

21802

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ orembe. Caroline Lavaughn Blenard 1103 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 □ M 2 🛣 Hours 217-12-2178 09708/1923 Director 86 PA Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Washington Hagerstown 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11017 Coventry Lane 21740 items 23a US within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No f Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Luther Wishard Anna Civilia Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11017 Coventry Lane, Hagerstown, MD 21740 LeeAnn F. Blenard / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other placel 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 109/25/2009 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Small Medical resulting in death) Examiner Sequentially list conditions, if any real statement cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by al Follore 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 25. Was case refe red to medica examiner? 2 No Yes 2 No 1 Yes Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D35764 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 37 12) MD 21742 31. Date filed (Month, Day, Year) State SEP 24 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Of IVIA	aryianu		rtificate of I			eg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deal Month	Day	Year	3. Time of Death
ane.	/Media		Donna May Boyd 4a. Facility Name (If not institution, give street and number)	_		4h City Town or	Location of Death	Septemb	er 23,	2009	9:45 p ^M
أأمها	Examir	ler	219 Summer Street			Hagers			Washi		n
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. las	* 1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ace (State or Foreign
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	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation				10	Od. Inside City Limits
	Mary I-f sh	tor	Maryland Washington	Hage	erstov	m					1 XYes 2 No
	or 28%)ire	10e. Street and Number	11491		10f. Zip Code		1	0g. Citizen of V	hat Count	ry?
	23a	ral	219 Summer Street			2174	40		USA		
	er dea	Funeral Directo	11. Marital Status 12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
38	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Expriner Tust be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10	1	□Yes 2XNo	Specify:		Specify	White	e
5-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	lent's Usual Occup	ation		16b. Kind of Bu	siness/Ind	ustry
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	iled w Hygie ther ti		17. Father's Name (First, Middle, Last)		order	Packer	18. Mother's Name				istribution
Maryland		To Be	Roland Critzman Mentzer					th Sarah		-,	
ar y		F	19a. Informant's Name/Relationship (Type. Print)	- 1	19b. Mailin	g Address (Street	and Number or Run				Code)
	rtr		James B. Boyd, II - Husband			Summer St		agerstow			
ore	# # # # # # # # # # # # # # # # # # #		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	20b. Plac	e of Dispos netery, crem	sition (Name of natory or other plac	e)	Date	20c. Location -	City or Tov	vn, State
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Ra	permit. Pages Department or Important: If i any Injury or once.		21. Signature of Funeral Sey of Licensee/		42	Name and Addres	es of FacilityOsbo	orne Fun	eral Ho	me,P.	A. 1D 21795
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5	ding Physician: The h. After this certificate h funeral director, page	<u>ان</u> کو	27. Manner of Death 28a. Date of Injury	y 28	Bb. Time of	28c. Injury	at Nursing Ho	me 5 Reside 28d. Describe ho			,
VISIOR	ttendin Jeath. tor: Af the fur	atio	1 Natural 5 Pending (Month, Day, 2 Accident investigation	rear)	Injury	M 1□1	? /es 2 □No				
Ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur building, etc.	ry - At home (Specify)	, farm, stre	et, factory, office		28f. Location (Sti City or Town		er or Rural	Route Number,
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	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. Ag the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	edical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination	and/or inv	estigation, in my op	ne, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and ma ate and place, a	nner as sta ind due to t	ited. the cause(s)
	within comp	Me	29b. Signature and title of certifier	1		29c. License	number	25	9d. Date signed	(Month, D	ay, Year)
(25		Mil Hama	lan	1/14))	46473	5 '	Septen	nber	,24,2009
	5		30. Name and address of person who completed cause of dea	ath (Item 23	Ba) (Type, P	Print)	- 11		1	. /	24,2009 D 21740
	Stat		31. Date filed (Month, Day, Year) 32. Recistrar	's Signature	Oh	HL C	1, 1	1gerst	swon,	M	D 71,140
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Marvin Lewis BOWER Sr. Month 100 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 Day, Yea March Director 215-14-2878 87 Maryland 1922 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 KÎ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 17310 Amber Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Force Black, White, etc þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 KNo Specify: Specify white Completed 3 Divorced 4 Divorced 1942-45 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) roofing sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Caroline Agnes Kuhn Jacob Lewis Bower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adelaide Bower - wife 17310 Amber Dr., Hagerstown, Maryland 21740 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Funkstown Cemetery 9/26/09 Funkstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 2. Name and Address of Facility MINNICH FUNERAL HOME Ε. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ 1270 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Rimeri Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? oTh Radisn 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed orters (co 2 No 1 Ves 25. Was cas referred to medical npleted filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury atural 5 Pending work? 2 | No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifie Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Decell 00 impleted cause of death (Item 23a) (Type, Print) ntietam St. Hageiston Registrar's Signature State 23

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** HENDERS /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner TAKOMA PARK ONTGOMERY ASHINGTON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 □ F 66-981 WASHY Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the finding. 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20722 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MARYLand filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surn 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOWIE Department of Health a Important: If item 27 Is any injury or other tra 10Y 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ORT LINCOLN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service C.2000. Part 1. Soter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the buria lor Attending Physician: The law requires that the death certificate be after death. Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobaccouse contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 les Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate 2 □No 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 ☐ Pending investigation 1 atural after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Menth, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar ess of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#19aperFH9-24-09, BMW, McCo Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 06:51 PM 2009 Scotember Helga Irmela Blazek /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimole 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2₺ F March 18, 1925 Germany Director 213-38-4532 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 5 or items 23a 9221 Whitney Street 20901 Germany death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iter 1 Never Married 2 Married aryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hecht Company 12 Inventory Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Reichal Herman Runge P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Mark Steven Blazek-Son 9221 Whitney Street, Silver Spring, Maryland 20901 Steven Blazek Baltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If It any injury or conce. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 9/25/2009 Brentwood, Maryland 4 Donation 5 Dother (Specify) Fort Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service License Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediale Cause (Final Physician UROCEPSIS unthown disease or condition resulting in death) /Medical Unknows Examiner Clostadium ditticle colitie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 1 No Day 5 ☐ Other (specify) cate has been signed by the page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 6 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 □Yes 2 10No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident s after death the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital within 24 hours a 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 68626 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI der 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 3 Registrar

TASEX

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		1 - State Registrar Ce	artment of Health and Nertificate of Death	Reg. No.	10 9193				
Physicia		1. Decedent's Name <i>(First, Middle, L</i> ast) Helen Nash Blachly		2. Date of Death Month Day September 21, 20	3. Time of Death 8:00 P				
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death						
		Manor Care of Chevy Chase	Chevy Chase	Montgom					
uneral irector		5. Social Security Number 579-66-5558 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday, 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) N	Birthplace (State or Fore Country) ew York				
wor		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Lin				
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or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	•				
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mark	욘		ing Address (Street and Number or Ru		ate. Zip Code)				
27 Is r trau		Frederick I O Blackly / Spance	O St. NW Apt. 231	•					
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To the Funeral Director: Aft completely filled in by the fun	Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Street) 28f. Location (Street and Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Numb							
e Funei letely fil	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.	propertigation in my opinion, double occur	errod at the time date and place, an	due to the cause(s)				
To the	Me	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type TRUONL MATERIAL PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY O	29c. License number	29d. Date signed (1)	Month, Day, Year)				
		30. Name and address of person who completed cause of death (Item 23a) (Type TRUONG KAO (0//) MCLECULAR	, Print)	a in 11116 MA	0 0 0 0				

DHMH 17 Rev 1/2001

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٦	Dhusia		1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physic /Medi		JOHN IRVIN BARBER SR.	SEPTEMBER 19 2009 4:02 PM
	Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	
			SOUTHERN MARYLAND HOSPITAL CLINTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	PRINCE GEORGE'S Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
l.	Funeral Director		219-48-3336 N 2 F 64 Yrs. Months Days F	Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) SEPT 4 1945 MARYLAND
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	the Marylan 28a-f show	jo	,	1 X Yes 2 □ No
	or 28a	Director	MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	23a o	a D	17100 FAIRWAY VIEW LANE 20772	USA
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. I then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examples country	by Funeral		anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: BLACK
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Maryland	1 and 2 sh Health and em 27 is n other traun			Number or Rural Route Number, City or Town, State, Zip Code) VIEW LANE UPPER MARLBORO, MARYLAND 207
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Ħ.	it. Pa irtmer irtant: njury		4□Donation 5□Other (Specify) PARKLAWN CEMETERY	9/26/2009 ROCKVILLE, MARYLAND
Bal	permit. Page Department of Important: If any injury or once.			VER ROAD LANDOVER, MARYLAND 20785
	Physician /Medical Examiner	jr.	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each implementation of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete	Approximate Interval Between Onset and Death Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles Charles C
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	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
ords, F	w requires tha s been signed should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	1 Part I. 23e. Did tobacco use contribute to the cause of death?
		Completed		24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
₹		o Be	Hospital:	. Place of Death (Check only one)
	ding h. After funer	ation: To	27. Manney Death 1 Pending 28a. Date of Injury 1 Pending 28b. Injury at Work?	4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 2 ☐ No
Division	To the Hospital or Attenwithin 24 hours after deal To the Fun ral Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Hornicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	n 24 hcu n 24 hcu ne Fun i	Medical	29a. Certifier (Check only one) 1 **Certifying Physis an: To the best of my knowledge, death occurred at the time, 2 **Method Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	date and place, and due to the cause(s) and manner as stated. on, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the I complet	Ň	29b. Signature and title of certifity 29c. License nu	
	17		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2) som with
2	l v	to	9/35 Of Scarfaring RJ S. T235 C	54 September, 20, 69 Pintor MD 20735
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 3 2009 August A. Sauce	

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryla	and / L	Certifica				Reg. No.	009	91965
Physici		1. Decedent's Name (First, Middle, Las Yvette Ther	,	el				2. Date of De Month	Day	2009	3. Time of Death 8:40 A M
/Medic Examin Funeral Director		5. Social Security Number 6. S	ce at the		e 5	alis.	Location of Deat	h 8. Date of Bir	4c. (County of Deat	h
and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Towr	or Location						10d. Inside City Limits
Maryl.	tor	Maryland Wicomic		2.	isbury						1 □Yes 2 🙀 No
vith the	Director	10e. Street and Number			10f. 2	Zip Code 21804				zen of What Co	untry?
r death v ems 23a er must	Funeral	340 Troopers Way 11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S.			spanic Origin? (S n, Mexican, Puerl	Specify Yes or No		4. Race - Ame Black, White	
ours after al", or it	by	1 ☐ Never Married 2 ☐ Married 3 😨 Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:			2 K No	Specify:	,			hite
2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland is marked other than "natural", or items 23a or 28a-f show aumaile event, the Macical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	-	life. DO NOT	vork done d use retired)	uring most of wor	rking		nd of Business/	
i filed v Il Hygie other i	Be Co	12 17. Father's Name (First, Middle, Last)	2	S	pervis		18. Mother's Nar	me (First, Middle			anufacturing
y could be Menta arked atic ev	To B	unknown					unknow	m			
12 # d		19a. Informant's Name/Relationship (7 Gerald A. Baseel/					Dr., El				Zip Code)
S = = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		b. Place of cemeter	Disposition (N y, crematory of	lame of r other place	9/2	Date 28/09		cation - City or	
- EE-		4 ☐ Donation 5 ☑ Other (Spent) 21 Signature of Feneral Service Licen		emory	's Gard	en Cer and Addres	metery s of Facility	Ilama Dies		any, N	ssociation
permi Depa Impo any Ir				SP	DOT !	snow r	illi ka.	, Salisk	oury,	MD 218	004
Physician		23a. Part 1. Enter the Jisease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.								Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	b. Due to (or as a cons	sequence	of):	4/11		4			
ted	Examiner	Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a cons	sequence	of):	Cin 1	505/3	BILA	TRA	AL	
tificate be executed g physician and as the burial-transit	al Exar	that initiated events resulting in death) Last	C. Due to (or as a cons	sequence (of):						
tificate ng physi as the t	ledical		.d			_					
ath cer attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c pregnancy (specify)	ncy			23d. Date of delivery Month Day Year				
res that the de signed by the be detached	þ	Part II. Other significant conditions or	23e. Did tobacco use contribute to the cause of death?								
w requires t been signe should be o	eted	107									robably 4 Unknown
iclan: The lar certificate has ector, page 2	e Completed	25. Was case referred to medical					00 Plant of Pa	1 ☐ Yes	psy ormed? 2 No	prior to death?	ntopsy findings available completion of cause of
Physicle this cert	To Be	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Ou	tpatient 3 🔲	DOA Othe		ath (Check only only only only only only only only		(□ ø ther <i>(Spe</i>	city) 4050163
Jing Pl	jon:	27. Manner of Death 1	28a. Date of Injury (Month, Day, Year	28b. 7	Time of njury	28c. Injury Work	/at ? /es 2 □ No	28d. Describe	how injury	occurred	1100
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.	Certification:	Accident investigation 3 Suicide 6 Could not be determined	1	t home, fa ecify)			765 2 1140	28f. Location (City or To	Street and wn, State)	d Number or Ru	ural Route Number,
e Hospita 24 hours e Funeral letely filler	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge nination an	e, death occurre d/or investigati	ed at the tim on, in my op	ne, date and plac pinion, death occ	e, and due to the urred at the time	e cause(s) , date and	and manner a place, and due	s stated. e to the cause(s)
To the vithin To the comp	Me	29b. Signature and title of certifier			2	9c. License				e signed (Mont	
book	-					Do	05841	0	09	1/16/0	9
1200		30. Name and address of person who can have was	completed cause of death (Item 23a)	(Type, Print)	5	HU 1	suy	us	2	1802
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	10- 11	,					

	1	State of Maryland / Department of Health and State Registrar State of Maryland / Department of Health and Certificate of Death	Mental F	lygiene .No.	7 11 11 9	31955
		1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death Day	/ Year	3. Time of Death
Physicia: /Medica		Alice Victoria Taylor Barnette	9	18	09	0915 M
Examine	r '	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl	h	4c.	County of Deat	h
end a		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of	Birth	1//// 9. Birt	hplace (State or Foreign untry)
Funeral Director		215-12-6001 1 M 2 X F 86 Yrs. Months Days Hours Min.	(Month,	Birth Day, Year) 3/1923		ryland
D D		Usual Residence of Decedent	107700	, 1000		
show	- 1	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 XNo
Ba-f	ecto	Maryland Wicomico Salisbury		10a Citi	izen of What Co	
### 21215-UU36 be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or items 23a or 28a-f show event, it e Medical Examiner must be notified at	Funeral Director	10e. Street and Number 1021 Pierce Ave. 10f. Zip Code 21804			USA	unuy.
ms 20	era 	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or	No-	14. Race - Ame	
after a		Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 Never Married 2 Married 1 Yes 2 X No 1 Yes 2 X N	to nicari, etc.)		Black, White	hite
Z15-UU36 hin 72 hours aft e. matical Exami	d by	3 🕅 Widowed 4 □ Divorced Year or Dates:		1 4Ch K		
"natı	lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	rking	160. Ki	ind of Business/	industry
d Z1Z1 filled within Hygiene. wher than "ent, ire the	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 7 - seamstress		clo	thing m	anufacturing
nd Z1Z1 e filed within al Hygiene. 1 other than " went, Ir. Me	a)	17. Father's Name (First, Middle, Last) 18. Mother's Name (Part Middle, Last)		ldle, Maiden	Surname)	
Taryland 2 should be file 1 and Mental Hy is marked oth raumatic even!	0	John Thomas Majors Annie	Ryan			
Mar nd 2 sho ulth and 27 is m r traum		19a. Informant's Name/Relationship (Type. Print) Victoria Abel/daughter 19b. Mailing Address (Street and Number or Ring) 6104 Foxtail Court,	ural Route Nu Salisk	oury,	or Town, State, 2 MD 2180	Zip Code) 1.
of Hear	Ì	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or	
Page Page ment ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	/23/09	Sal	isbury,	MD
Baltimore, permit. Pages 1 ar Department of Hee Important: If item any Injury or othe		22 Signature of Funeral Service Licensee 22 Name and Address of Facility Holloway Funeral 501 Snow Hill Rd.	Home P	rofes	sional A	Association 304
	1	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician						Onset and Death
/Medical		Immediate Cause (Final disease or condition resulting in death) a. Acros Renal for her for her for heart for her for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart for heart fo				
Examiner		Sequentially list conditions. b. Congestive heart failure				
sit ed	aine	if any, leading to immediate cause. Enter Underlying				
xecut and	Examiner	Sequentially list conditions, if any, leading to time office cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
icate be executed physician and the burial-transit	dical	d				
tifficating phy as the	edi					
death certif	an/N	## FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of de	
the dea	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)	·	-	Month	Day Year
d by t	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. [Did tobacco	use contribute to	o the cause of death?
	o k	Part II. Other significant conditions continuously to death out not resulting in the disconying deader given in react.				robably 4 Unknown
Hecords, he law requires t e has been signe age 2 should be o	Completed			Vas an	T	utopsy findings available
VITAI HEC. sloian: The law is certificate has b irector, page 2 st	m d		a p	utopsy performed?	prior to death?	completion of cause of
= 0		25. Was case referred to medical 26. Place of De	1 □ Ye		1 L Yes	s 2□No
Of VITA Physician: rthis certific ral director,	o Be	examiner? Hospital:			6 ☐ Other (Spe	ecify)
on of Vital iding Physician: th. Tafter this certifice funeral director, is	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 4 Work?	28d. Descr	ribe how inju	ry occurred	
SIOI eath. or: A	catic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
DIVISION I or Attending after death. I Director: After d in by the fune	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		on (Street ai r Town, State		ural Route Number,
	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred and manner stated.				
o the vithin 2 or the omple	Med	29b. Signature and title of certifier 29c. License number		29d. Da	ate signed (Mon	th, Day, Year)
T SF O		D68222			09-18	- 09
CAI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
DVC		RAZA AFZAZ 1415 S. Division St, Ste B Salisbury MD	21804	1		
Stat Registra		31. Date filed (Month, Day, Year) SFD 2 2 2000 32. Registrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10e per FH & 23a per phys G896 10/6/09 dk
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 201

		-	For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cer	tificate of L	Death		Reg. No.	nno	3 95
	Dhysisis		1. Decedent's Name (First, Middle, Las	et)				2. Date of De Month	Day	Year	3. Time of Death
	Physicia /Medic			AED BUTT	<u>S</u>			8		209	11: 116W
	Examin	er	4a. Facility Name (If not institution, give	4		4b. City, Town, or	Location of Death		4c. County	of Death	
A.			5. Social Security Number 6. S		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Bir	th		ace (State or Foreign
	Funeral Director			M 2□ F 6!		Months Days	Hours Min.	Dec. 2	ı <i>y</i> , Yea <i>r)</i>	Count Maryl	
	land ow		10a. State 10b. County	10c. C	City, Town or Lo	cation				10	d. Inside City Limits
	Mary Ind s	io	MD Washingt	on Ha	agerstov	√n					1∭Yes 2☐No
	or 282	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	23a c		62-8. Main St.	643 Washingt		2174				.S.A.	
	tems tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No o Rican, etc.)	b- 14. Rad Blad	ce - America ck, White, et	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if we fleat Evaruinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ∑Yes 2 □ No If Yes, Give Year or Dates:	_	1⊡Yes 2 X No	Specify:		Specif	y: Whit	e
9	2 hou	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Deced	dent's Usual Occup	ation	kina	16b. Kind of B		
21	within 7 iene. • than "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	1)	9			
121	thould be filed within and Mental Hygiene. marked other than imatic event, the Marken	ខ	17. Father's Name (First, Middle, Last)			Che	18. Mother's Nan	ne (First, Middle		Servi	.се
anc	d be fi	Be C	Raymond A. Butts				Myrtle	•	rper		
Maryland 21215-0036	2 should be and Mental Is marked of aumatic ev	ဥ	19a. Informant's Name/Relationship (Турө. Print)	19b. Mailir	ng Address (Street				, State, Zip	Code)
	alth a		Brandy Kirby / I	nformant	2513	Buchanar	n Trail (Greencas			ania 17225
ore	es 1 and of Heal f item 2 r other		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐	20b.		sition (Name of matory or other place		Date	20c. Location	- City or Tov	wn, State
Ĕ	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Specif	y) Str		g Cremat	ory 8/21	/2009	Smiths		
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service	see		2. Name and Addre			en Fune		hapel 21742
	## ## ## ## ## ## ## ## ## ## ## ## ##		23a. Part 1. Enter the disease, or com	plications that caused the de		01 Penns				, PID	Approximate
			shock, or heart failure. List only	one cause on each line.				, ,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse		Attacl	<u></u>			-	
Tar.	Examiner	Coronary Artery Disease									
	P .E	ner	Sequentially list conditions, trans, leading to in moderate cause. Enter Underlying	Due to (or as a conse	consequence of :						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
68760,	death certificate be executed e attending physician and of for use as the burial-transit				equentee on.						
687	ificate g phys	Medical		d							
Box	n certi		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		⊒ Ectopic pregnanc	***			ate of delive	
O. B	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of		Other (specify)	-		l M	lonth	Day Year
P.	hat the id by t letach	Phy	9 Unknown Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to th	ne cause of death?
of Vital Records,	requires that the been signed by th hould be detache	d by						1 🗆	Yes 2 □ No	3 ☐ Prob	oably 4 🗆 Unknown
CO	law req as beer 2 shou	Completed						24a. Was		. Were auto	psy findings available
Re	sician: The law certificate has birector, page 2 s	mo						peri 1 □ Yes	opsy formed? 2 X No	death?	mpletion of cause of 2 □ No
ital	lan:	BeC	25. Was case referred to medical examiner?					ath (Check only			
<u>></u>	> 0 0		1 Yes 2 No		☐ ER/Outpatie		4 Li Nuising i	T-	sidence 6 🗆 O		(y)
o u o	ding Phy h. After thi funeral	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat k?]Yes 2 □No	28d. Describe	how injury occu	rred	
Division	l or Attending after death. Director: After in by the fune	ertification: To	2 Accident investigatio 3 Suicide 6 Could not b	e 28e. Place of Injury - At	home, farm, st		Ties Z Lino			nber or Rura	al Route Number,
Div	al or A after I Direct	ertii	4 ☐ Homicide determined	building, etc. (Spe	ecify)			City or To	own, State)		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical C	29a. Certifier 1 CertifyIng P (Check only one) 2 Medical Exa	hysician: To the best of my liminer: On the basis of exam and manner stated.	knowledge, dea ination and/or in	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) and re, date and place	manner as s e, and due to	stated. the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier		-	29c. Licen	se number		29d. Date sign	ed (Month,	Day, Year)
			1	d.M.	•	AU 41	764359	318176	81	18	09
			30. Name and address of person who	completed cause of death (I		Print)				P4100	
			31. Date filed (Month, Parkar)	32. Registrar's Sign		ene st	reet B	altimo	re, Mi	215 4	201
	Sta Regist		or pare med (world), OCT of	2009 Lenna	1	hadel					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sopkenber Physician/ 2009 1750 Rose Mary Crabtree Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Hospital Hagerstown Washington County 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Y August 1 1922West Virginia 1 M 2 N F 87 Director 232-26**-**7274 Usual Residence of Decedent 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Washington Hagerstown Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21740 U.S.A. 353 East Franklin St. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Machine Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ Saladini <u>Pasquale</u> Saladini 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Grand 17820 Woodvale Ct. Hagerstown Maryland 21740 Richard S. Wolfensberger_ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 9/24/2009_ Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Sign turn of Funeral Socvice Licens ee Pennsylvania Ave Hagerstown Maryland 21742 1601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last 3 e 5 Physician/Medical 6 Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Yea 4 Pregnant at time of death
9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 TYes 1 Impatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 🗖 Natural 5 Pending hours after death. neral Director: Aft d filled in by the fur 1 Yes 2 No 2 Accident Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signature DO 60 OZ

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 4 200

FARIO

31. Date filed (Month, Day, Year)

MUNSHED

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death p 200 g September **Physician** -28 M Allen Carter William /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NICOMICO 5401364V KENINSULA SEGIONAL POICAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ▼ M 2 □ F 68 578-54-1317 11-16-1940 Washington, DC Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location f show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, it e Medical Examinar is unit to notified at 1XYes 2 □ No Director MD Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 379 Dueling Way U.S.A 21811 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat once. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>ک</u> Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S Government Civil Servant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Ballard Carter Laura Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 379 Dueling Way Berlin, MD 21811 Sharon W. Carter / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -21-2009 Suitland, MD Washington Nat. Cem. 22. Name and Address of Facility Rausch Funeral Home P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2-3 04-45 **Physician** a. Due to (or as a consequence of): OREAN FAMILY /Medical Examiner TOO COROLLEDY MATERY BRASS MD MITRA VALLE REPLEMENT KEDO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
P. From the attending physician and preventificate has been signed by the attending physician and Due to (or as a consequence of): WECKS burial-tra Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 C Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 Q N 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number 2009 Dx 355 16

DHMH 17 Rev 1/2001

State Registrar

day 5

salisbury MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mD

2009

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32. Registrar's Signature

Ioda

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛴 Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 8:23AM 19 2009 SEPTEMBER Concetta V. Canfora /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Berlin Nursing Home Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 0ct 11 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F PA 85 191-12-3919 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 2 should be filed within 72 hours after death with the Maryla nand Mental Hygiene. I sand Mental Hygiene. I see its marked other than "natural", or items 23a or 28a-f show its marked other than "natural", or items to not marked the confinct and the word, the Modicial Examinant intelligence of the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confined and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and the confinct and t 1 ☐ Yes 2√ No Director MD Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21811 54 Moonraker Rd. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married CANFORA CONCETTA 1 ☐ Yes 2 ☐ No Specify: Specifywhite ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) accounting firm book keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Assunta Granata Injury or other traumatic ျှ Stefano Vendemia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau 27 Footbridge Trail Berlin, MD 21811 Susan Canfora (daughter) 20b. Place of Disposition (Name o 20a. Method of Disposition Pages 1 Shore 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 9/23/09 Hurlock, MD Vetrans 22. Name and Address of Facility The Burbage Funeral Home A Service License 108 William St. Berlin, Md 21811 una complications that oal sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause only a hine, Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jessee Higher) that initiated events resulting in death) Last Due to (or as a consulence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 24 hours after death.

Funeral Director: After thi etely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RA2

within 2

State Registrar 29b. Signature and title

Name and address of person who comple 31. Date filed (Month, Day, Year)

SEP 22

d cause of death (Item 23a) (Type, Print thway Dr Berlin

License number

29d. Date signed (Month, Day, Year)

-07262 rek James Cod	ok	Please Type or Print in Black State of Maryland / De	epartment o	of Health a	re All Copic nd Mental H	es Are Legi ygiene	ible.	00 0107
	R	For State (Certificate o	of Death			. No. 6	3. Time of Death
Physicia edical Examin	1/4	Derek James Cook				Month I September		1410 hrs
		a. Facility Name (if not institution, give street and number) 10248 Hickory Ridge Rd Apt 201		Columbia	or Location of Deat		4c. County of Dea Howard	ith Birthplace (State or Foreign
Funeral Director	5	. Cooler Cooler, Manual	rrs. last birthday) 26 y	If Under 1 Your Months Day	ear If Under 24Hr ays Hours Min			Country)
w any			City, Town or Loc					10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show any notified at once.	Director	Oe. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		10248 Hickory Ridge Road		210		Procify Yes or No.	USA	erican Indian, Black,
eath with	Funeral	1. Marital Status 1. X Never Married 2. Married	1	Was Decedent of the If Yes, specify Cub	Hispanic Origin? (\$ pan, Mexican, Puert	o Rican, etc.)	White, etc.	
after de	by F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X	No specify: pation (Give kind or	work done	Specify:	White
2 hours	ed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	during	most of working	ife. DO NOT use re	etired)	Applied	Physics
5-0036 lled within 72 Hygiene. I other than the Medical	ompleted	5+	Ele	ctrica	Engine	eer ne (First, Middle, M		ns Hopkins
e filed very feet of the other of the	Be Co	17. Father's Name (First, Middle, Last) William R. Cook			Beth	Anne Sv	vinger	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	2	19a. Informant's Name/Relationship (Type, Print) Beth Cook/Mother					ber, City or Town, St	rque, N.M.
e, MD L and 2 sho Health and item 27 is	ŀ	20a. Method of Disposition	20b. Place of Dis	position (Name of rother place)	cemetery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 X Burial 2 Cremation 3 X Removal from State 4 Donafton 5 Other Specify:	Gate o	f Heave				erque, N.M.
Balt permit Departu Import injury		21. Sign wife of Funeral Service License						ICE,P.A. ing,Md20910
Physician Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.			ng, such as cardia	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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	ē	Sequentially.list conditions, if any, leading to immediate b. Due to (or as a conseque	ence of):					
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Box 68760, c death certificate be execut the attending physician and edfor use as the burial - trai	cian/	23b. Was decedent pregnant in the past 12 months?	e of death 5	Fetal death Other (Specify)	3 Ectopic pre	gnancy	Month	Day Year
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	2 Accident Investigation Sep 16, 2009 3 Suicide 6 Could not be 28e. Place of Injury	1410 hr - At home, farm,		fice building, etc.	28f. Location or Town,	(Street and Number of State) ry Ridge Rd Apt 20	or Rural Route Number, City
Diviospital or a hours after uneral Direction by filled in 1		4 Homicide determined (Specify) Multi-	nowledge death	occurred at the tin	ne, date and place,	and due to the cau	use(s) and manner as	s stated.
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examinand manner stated.	ation and/or inve	stigation, in my or	inion, death occurr	ed at the time, date	e and place, and due	to the cause(s)
20	Me	29b. Signature and title of certifier			cense number C.M.E.		September 1	(Month, Day, Year) 7, 2009
		30. Name and address of person who completed cause of deal	th (Item 23a)					
		Ana Rubio MD. Assistant Medical Examin	er 111 Pe		timore, MD 21	201		
S Regis	tate	31. Date filed (Month, Day, Year) 2. Registrar's Lewis	J. Ja	all				

			For State Registrar	State of Mai	ryland / I		rtment o			and M		iene eg. No. /		3 97
	Physici	an	1. Decedent's Name (First, Middle, La		·c						2. Date of Deal Month SEPTEM		Year 2009	3. Time of Death 4:05A M
and the second	/Medic Examin	al	4a. Facility Name (If not institution, given 9223 BRIARCHIP		.5		4b. City, Tov		ocation o	f Death	SEI LEG	4c. Cour	ty of Death	ORGE'S
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	with the	Director	10e. Street and Number				10f. Zip Co					0g. Citizen	f What Cou	ntry?
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altimore,			20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		cemete	erv. crema	atory or othe	er plaçe	ERY 9			LAUREL	-	IARYLAND
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee		22.	Name and	Address	s of Facility	у J.	B. JEN LANDOV			
	Physicían /Medical Examiner		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused to one cause on each line PROSTA. a. Due to (or as a	E CANO	CER	r the mode o	of dying	ı, such as	cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
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Ω	To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the	Medical Cer	29a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of and manner stat	examination a	ge, death and/or inv	occurred at estigation, in	the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
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Ŕ	12		30. Name and address of person who SYDNEY M. DY M.					ET	# 609	BAI	TIMORE	MARYL	AND 2	20785
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 3 2009	32. Registra										

DHMH 17 Rev 1/2001

B!		1. Decedent's Name	e (First, Middle	e, Last)								2. Date of D)ay	Year	3. Time of I	Death/
Physicia /Medic		Isra	ae1	Cadiz								Sept.	18,	2009		8:40	p ^M
Examin		4a. Facility Name (i	If not institution	, give street and	number)			4b. City,	Town, or	Location	of Death		4	c. County	of Death		
		5214 56								ille	- 1 ()					eorges	
Funeral Director		5. Social Security N 635-01-6	313	6. Sex 1 □ 3 M 2 □ I		e (In yrs. las 75	t birthday Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of E 09/14/	1932	(r)	9. Birthp	lace (State or try) alvado	Foreign
and		Usual Residence of 10a. State	10b. County			10c. City,	Town or L	ocation							1	0d. Inside Cit	y Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	Completed	Elementary/Seco		1	e (1-4or 5	i+)	life.	inten:	se retired	1)		ing	()ursi	nan (ar Dea	ıler
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Physician /Medical	4	disease or condition resulting in death)	on	и		ant N		ism, V	erte	bral	Col	um n					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

State of Maryland / Department of Health and Mental Hygiene

								Certific	cate of	Death		Reg. No.	09	311	975
	Dhusisia		1. Decedent's Name (First	st, Middle, Las	st)						2. Dete of D Month	eeth Dey	Year	3. Time o	of Death
-Degr.	Physicia / Medic/		Shirley De	nise (Crandall							nber 17,		5:1	5 PM
	Examin		4a Fecility Neme (If not in	nstitution, give	street end number)					4b. City, Town,	or Location of Dee		y of Death		
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×	Funeral Director		5. Social Security Numbe 072–18–5820 Usuel Residence of Dece	1	ex 7. Ag □M 2ŽŽF	e (In yrs. I 84		rs.	nder 1 Year hths Days		in. Oct 1	nth ay, Year) 3, 1924	9. Birthpi Count Mass	lace (State try) achuse	etts
	pue & m	-		County		10c. City	y, Town	or Location			-		10	0d. Inside C	City Limits
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	1 the	Director	10e. Street end Number	000220	•	1-0.0.			f. Zip Code			10g. Citizen of	What Coun	try?	
	ath with the Marylenc 23a or 28a-f ehow 22t be notified at		3200 Baker	Circle				2	21710			USA			
	fter deat r items 2	Funerai	11. Maritel Status		12. Was Decedent	Ever in U,	S.	13. Was D	ecedent of	Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)		ce - Americack, White,		
020	urs e	۾	1 ☐ Never Married 2 3 🌠 Widowed 4 ☐ D		Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No				Specify:	iono moan, oto.,		whit		
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Baltimore, Maryland 21215-0020	# = F	- 24	1 ☐ Burial 2 ☑ Cred 4 ☐ Donation 5 ☐ C	mation 3 D Other (Specify)		-	Journe		ematory	Sept.19 2009	Woodbin	e, MD		
Bal	pemit. Pag Department Important: I any Injury o pnce.	1	21. Signature of Funeral	Service Licen:	Le Otto	MO12	:51	Going	g Home		ion Servi				21029
		7	23a. Part1. Enter the dis- shock, or heart failu	eese, or comp	olications that caused			ot enter the	mode of dy	ing, such es card	diac or respiratory	arrest,	-	Approxima Interval Be	ate
4.	Physician												1	Onset and	Death
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0	ding Ph h. After thi funerel		27. Menner of Death 1 ☑ Naturel 5 □	Pending	28a. Date of Inju (Month, De	y Yeer)	28b. Ti	jury	28c. Inju		28d. Describe	how injury occu	rred		
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Division of Vital Records,	or Atta	Certification:	3 ☐ Suicide 6 L 4 ☐ Homicide	determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, far	m, street, fa	ctory, office			(Street and Nun own, State)	iber or Rura	il Route Nur	mber,
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0 9 **Physician** 2009 4:15 A M Carstairs Mae Rhoda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospital Elkton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 80 Yrs Months Days Hours Min. 1 □ M 2 🖫 F 211-22-2616 PA Director 9-15-1929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show traumatic event, the Medical Exertiner must be notified at Director 1 ☐ Yes 2 ☐ No New Castle Newark DE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ö 117 Pine Drive 23a 19713 USA Funeral 72 hours after death items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 □Yes 2X Wo Specify þ Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any Injury or other traumatic event, I'm Mad gonge. Elementary/Secondary (0-12) College (1-4or 5+) District 12 Teacher's Aide Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Scott Winfield Gross ပ Stella Ofer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 217 West Silver Fox Road, Newark, DE 720

se of Disposition (Name of letery, crematory or other place)

Date 20c. Location - City or Town, State Connie Feeley/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans 09-232009 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Cemetery Strano & Feeley Family 19720 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Home 635 Churchmans Road Newark 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö been signed by the should be detached 1 □Yes 2 □No 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2☐NO 3☐ Probably 4☐ Unknown 1 ☐ Yes . Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page certificate ! performed HUDEN TENSION 1 ☐Yes 2 ☐No Division of Vital 1 ☐ Yes 2. No After this certific funeral director, 25. Way ase referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/2/No 1☐Inpatient 2☐ER/Outpatient 3☐DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eath (Item 23a) (Type, Print) 30. Name and address of person who co poleted cause of XIV (Ja Va 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 2009 50 AM Dale Collins 01iver 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 30/1364My HICOMIC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 7,1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Maryland 1⊠ M 2□ F Months Days Hours Min. Yrs 89 May 219-07-6013 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 306 West London Avenue 21801 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1⊠Yes 2□No 1947-Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White 3 → Widowed 4 Divorced 1949 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Governmet Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oliver Dale Collins, Sr. Pearl West 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 West London Ave. Salisbury, MD 21801 Deborah Kay Collins- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/22/2009 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery Salisbury, Maryland Funeral Service, Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E Main Street Salisbury, MD 21804 23a. Part 1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or r. spiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final : Frisns disease or condition resulting in death) Due to (or - a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed expects.) Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the fredient Examinat must be notified at

and Mental Hygiene.

of Health a

other Department of Healt Important: If item 2 any injury or other once.

death

72 hours after

Pages 1 and 2 should be

permit.

Hospital or Attending Physician: The law requires that the death certificate be executed

has

this certificate

After thi funeral

within 24 hours after death.

To the Funeral Director: An completely filled in by the fur

Box 68760.

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of Vital Records,

Division

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending properties for use as the a signed by to

Examiner Physician/Medical þ

Certification: To

Medical

State

Completed page 2 Be

IF FEMALE 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown

24a. Was an autopsy performed? 1 □ Yes 2 🗄 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

(Check only one)

29b. Signature and title of certifie

5 ☐ Pending investigation

1 Inpatient 28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

and manner stated.

2 ER/Outpatient 3 DOA 28h Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

29c. License numbe.

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital:

29d. Date signed (Month, Day, Year)

30. Name ddress of person mpleted cause of death (Item 23a) (Type, Print)

A (c & OC Year 2 31. Date filed (Month 2

Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician September Judith Elaine Carnev 1446 18 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 3145640 VICOMICO PENINSULA REGIONAL CONTU 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Months 221-44-2432 1 □ M 2 🕱 F 54 Delaware 09/14/1955 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 V No Director Maryland Worcester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21813 USA 12805 Old Stage Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 1 1. 1 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) service industry retail sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Edward Bertrand Jean Ellen Magee 2 19a. Informant's Name/Relationship (Type. Print)
Joy Hoffman/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1034 S. Schumaker Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 9/21/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signatu e of Fun ral Service Licensee ²². Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 price H. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS 20445 Due to (or as a consequence of): MULTIPLE SYSTEM ORGAN FALLULE 2 w995 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consecuence off REPLACEMENT REDO MITZAL VANG 3 weeks Due to (or as a consequence of) hysician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 1? own able

the death certificate be executed P.O. Box 68760, Division of Vital Records.

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan De, ariment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Eventinat be notified at any

Physician

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Examiner

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Baltimore, Maryland 21215-0036

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The law requires that the de ate has been signed by the age 2 should be detached	by	Part II. Other significant conditions of	contributing to death but not res	sulting in the underlyin	g caus	se given in Part I.			se contribute to the cause of death
The law recate has be page 2 sho	Completed						-	24a. Was an autopsy performed? 1 □Yes 2 □No	24b. Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 □ No
ian ian itifi	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Ci	heck only one)	
Physician: r this certific ral director,	To E	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 □	DOA	Other: 4 \sum Nursing	Home	5 ☐ Residence 6	G ☐ Other (Specify)
ng Afte	ertification:	27. Manner of Death 1		28b. Time of Injury	28c.	. Injury at Work? 1 □ Yes 2 □ No	28d.	Describe how injury	occurred
al or Attendi	Certific	3 Suicide 6 Could not be determined		ome, farm, street, fac ify)	tory, of	ffice	28f.	Location (Street and City or Town, State)	d Number or Rural Route Number,
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Vithii	ž	29b. Signature and title of certifier			29c. L	icense number		29d. Dat	e signed (Month, Day, Year)
2		1 4			1	053551		SEP	T 21, 2009
51		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)					
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Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	4			/	
Registr	ar	SEP 2 2 20	209 Comme	A. Spark	_				
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				ORIGINAL	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 19 **Physician** 2009 \$eptember 5:44P M John Charles Doran, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Berlin Nursing Home Worcester Berlin If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. Hours 1**√X**M 2□ F Days 79 090-22-1930 Director July 13,1930 NY Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Marian Examination and once. Director Worcester 1 ☐ Yes 2 No Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 165 Ocean Parkway Funeral 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. the Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Doran, Sr. John Baltimore, Maryland 21215-0036 1 ☐ Yes 2XTXNo Specify. White þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Utility 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည John Doran Helen Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Doran, Jr. / Son 8365 Gartelman Farm Dr., Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/24/2009 | Glen Burnie, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Jun 22. Name and Address of Facility Burbage Funeral Home 108 Williams Street, Berlin, MD. 21811 23a. Part 1. Inter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Examine Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 □Yes 2 **X**No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending e Funeral Director: A fetely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours af To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only

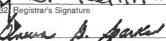
BA 7+1

State Registrar

Health 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific



1186

Pennie Savage

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SEPTEM BER Elvira Bernardo Desiderio 10:35 PM 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 5 , 19 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 I Hours Min. 50 220-02-3380 Director opines Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. aut. If Item 27 is marked other than "natural", or items 23a or 28a-f sho aut. If Item 27 is marked other than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Germantown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20800 Spinning Wheel Place 20874 U.S.A.12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Philippino Completed 3 Widowed 4 Divorced Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hermogenes Bernardo Florencia Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2402 Bright Seat Rd. Apt T2 Landover, MD 20785 Ria Desiderio (Daughter) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State September permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Smithsburg Crematory 2009 Smithsburg, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 Jelle 12525 Bradbury Ave. Smithsburg, Maryland 21783 130 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ neumen/a 1471 cm disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and deepached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to cleath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' (ivadi this certificate 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? (<u>P</u> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral . Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. Ineral Director: After 1 Natural 5 Pending work 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier HOSPITALIS 29d. Date signed (Month, Day, Year) 400611 otembe 0000 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 E nancesco onreli

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

32. Pegistrar's Signature

RISTOL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** Carol Lee Frantum 12:37 AM 09 -9 -2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salis bury Coastel Hospice at the Lake Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/08/1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F New York 216-34-1066 71 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Wicomico Pittsville 1 Tyes 2 XNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34456 Workman Road 21850 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry uld be filed within 72 h Mental Hygiene. Elementary/Secondary (0-12) Sollege (1-4or 5+) poultry industry secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Eisemier Marjerie (unknown) Pages 1 and 2 should or other traumatic 2 19a. Informant's Name/Relationship (Type. Print)
Edwin R. Frantum Jr/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34456 Workman Rd., Pittsville, MD 21850 permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 2 and 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 an Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 9/22/09 Salisbury, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
HOIloway Funeral Home Professional Association Torrid A. Chompson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ancer years Lun /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off sician and burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician hed for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☎ No 24a Was an 1 ☐Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗷 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier geres Vh. 12el 0. Name and odress of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D.: 5302 CHINABERRY DR., SALISBURY, MD 21801 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State SEP 22

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Theresa Weber Glaser /Medical SEPTEMBER 22, 2009 3:05P.N 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Boonsboro Washington 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 1, Funeral 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 F Days Months Hours 214-22-7685 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 1XYes 2□No Director Maryland | Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 141 South Main Street 21713 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: 3 ☐ Widowed 4 ☑ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Transcriptionist Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Milton Weber, Sr. Mary Kowiak ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen R. Buck / Daughter 11907 Wesley Drive Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 XCremation 3 Removal from State Stauffer Crematory 09-24-2009 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libenses Bast-Stauffer Funeral Home, P.A. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 7606 Old National Pike Boonsboro, MD Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Arteuro scherkie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 0 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Rementi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 1 □Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Linuxing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 1 Tes 2 AHO 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the မ

State

Medical

SEP 25 2009 Registrar

(Check only one)

29b. Signature and title of certifier

(at mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. VASANT DATTA, 340 MILL STREE
31. Date filed (Month, Day, Year)
32. Registrar's Signature STREET, HAGERSTOWN, MARYLAND 21740

29c. License number

0 18019

29d. Date signed (Month, Day, Year)

SEPT 23 2009

301-739-7100

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			Prince George's Hospital	Cheverly		Prince Ge	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day,	rear) Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		2/11/1	924 Wash	nington, DC
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E	Page nent on int: If		Tea Bullat 2 Dicternation 3 Differnoval from State	ns Cemetery 9/2	8/2009 0	Cheltenham,	Marviand
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		113 / 00024	Name and Address of Facility		4739 Baltin	
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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Records,	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Completed	Acute Renal Failure		24a. Was an		ppsy findings available
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	o the Hospital or At Ithin 24 hours after o the Funeral Direc επρletely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invegence and manner stated.	stigation, in my opinion, death occu	rred at the time, da	ite and place, and due t	stated. o the cause(s)
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1	14+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri			11-7	
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			For State Registrar			State of	Marylai		artment of rtificate of		and Me		gien Reg. N	000		31984
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Item Item 25 is not in the Item 25 is not injury or other traumatic event, Item Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 150 in the Item 15	y Funeral	11. Marital Status 1 Never Marri			12. Was Deced Armed Ford 1 Tes 2 If Yes, Give	ces? 2 🗶 No		Was Decedent of If Yes, specify Cub	oan, Mexican	gin? (Spec i, Puerto R	cify Yes or No lican, etc.)	-	14. Race - Ai Black, Wi Specify:		ndian,
21215-0036	hours tural";	ed by	3 Widowed			Year or Da			dent's Usual Occu				16h	Kind of Busines		Mite
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pu	al Hy al Hy I othe went,	Be	17. Father's Name ((First, Middi	le, Last)					18. Mothe	r's Name	(First, Middle,	Maide	n Surname)		
<u>yla</u>	Ment Ment arkec atic e	卢		E	Clija	h Gordy						Evelyn	Beal	.1		
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Baltimore, Maryland	t. Pages 1 and 2 thent of Health a tant: If Item 27 is ljury or other tra		1 ☐ Burial 2 ☐ 4 ☐ Donation	☑ Cremation 5 ☐ Other	(Spepity		iaie	ort Linco	osition (Name of matory or other pla oln Cremato	ry	09/24			entwood,		
Bal	permit Depar Impor any in		21. Signature of Fu	neral Service	e Licen:	Deuto	u _	43 H	2. Name and Addr ines-Rinal d 1800 New H a	li Funer	al Hor		er S	Spring, M	aryla	nd 20904
	Physician /Medical		231 Part 1. En or the shock, or heal Immediate Cause (disease or condition resulting in death)	rt failure. Li Final	or comp	a. K	ch line.	la Sepsi	ter the mode of dy		cardiac or	respiratory a	rrest,		Inte	proximate erval Between set and Death
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68760,	icate be executed physician and the burial-transit	edical Exa	resulting in death) L	_ast	l	Due to (o	r as a consec	quence of):								
P.O. Box 68	t the death certifi by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?			rth 2 ☐ Feta ant at time of	al death 3[⊒ Ectopic pregnan ⊒ Other <i>(specify)</i> _	су				23d. Date of o	delivery Day	/ Year
	es tha igned be det	by P	Part II. Other signifi	icant condi	itions co	entributing to dea	ath but not res	sulting in the u	nderlying cause gi	ven in Part I.		23e. Did t	obacco	use contribute	to the ca	ause of death?
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of Vital Records,		Completed										24a. Was autop perfo 1 ∐Yes	osy rmed?	prior t death	to comple	findings available etion of cause of
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of	Phys rthis raldir	٦.	1 ☐ Yes 2 🔀			1 🗷 in		ER/Outpatie	III 3LJ DOA			e 5 🗆 Resi		6 ☐ Other (S	pecify)	
on	Attending Physician: r death. ector: After this certifica by the funeral director, p	ţi	1 X Natural 2 ☐ Accident	5 Pend	ding stigation	(Month	, Day, Year)	Injury	Wo	rk?]Yes 2∐1		ou. Describe i	iow iiiji	ury occurred		
Division	al or Attend after death Director: / d in by the f	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Coul		28e. Place o	of Injury - At h g, etc. <i>(Spe</i> c	ome, farm, str ify)	reet, factory, office			Bf. Location (City or To	Street a	and Number or te)	Rural Ro	ute Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one)	1 X Certify 2 Medic	ying Phy al Exam	ysician: To the bai iner; On the bai and manne	sis of examin	owledge, deat ation and/or ir	th occurred at the to	ime, date an opinion, dea	id place, a th occurre	nd due to the d at the time,	cause date a	(s) and manner nd place, and o	r as state lue to the	d. cause(s)
	Within Sound	M	29b. Signature and	title of certif	fier	1			29c. Licen	se number			29d. D	Septembe		
		-	30. Name and addre	ess of perso	on who o	ompleted cause	of death (Ite	m 23a) (Type,						pecimoe	,	
									d, Silver S	pring,	Maryla	and 2091	.0			
	Sta Registr	16	31. Date filed (Mont	P 23	200		gistrar's Sign	ature 1. Jan	Med							
						4	•	7.4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 20, 2009 12:47 A Bertrum Glick /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Ft. Washington Ft. Washington Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 6. Sex **Funeral** Months Days Hours 1**XX**M 2□ F January 14, 1922 Washington, DC 579-18-0370 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f shov 1 □Yes 2 KNo Director Maryland 1 4 1 Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2204 Jerome Drive 20744 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ No 1942-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withii Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 2 years U.S. Air Force Military Musician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Conrad Glick Anna Woods ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patrick Glick / 2204 Jerome Drive Ft. Washington, Maryland 20744 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 9/25/2009 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signat 1/2 f Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** ILATED 8.5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 5 Other (specify) 1 □ Yes 2 □ No Ö been signed by the should be detached 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by monan 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year)

State

Registrar

MMO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VARNER

Deidra

31. Date filed (Month, Day, Year)

SEP 2 3 2009

D0033519

11701 Livingston Rd Ste 203; PT. WASHINGTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year David Leroy Hawbaker, Sr. September 23 2009 12:09 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 17128 Virginia Ave. Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Hours 1 M 2 □ F 217-28-1277 76 March 15,1933 Maryland Usual Residence of Decedent 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Washington Maryland Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17128 Virginia Ave. 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 1952
If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 21 Married 1952-1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced Year or Dates White 1955 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Beverage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rush Hawbaker, Sr. Mary Bryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Hawbaker - Wife 17128 Virginia Ave. Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Sp. Cedar Lawn Mem. Park Sept. 25, 2009 Hagerstown, Maryland 21. Signature of Funeral S Osborned FuneralityHome, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IV Non-Small Cell Lung Cancer Stage Due to (as a years Sequentially list conditions, if any, leading to financial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-Division of Vital Records, P.O. Box 68760, physician the attending use jo detached signed by page 2 should be has been certificate within 24 hours after death.

To the Funeral Director: After this certific reempletely filled in by the funeral director, Hospital

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Examine

by Physician/Medical

Completed

Be

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

IF FEMALE

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f show event, the Medical Examination must be redified at

other

Department of Important: If any injury or once.

Physician

/Medical

		contributing to death but not resulting in the und	. 0	e given in Part I.		se contribute to the cause of death?] No 3 ☐ Probably 4 ☐ Unknown
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case refer examiner?	red to medical			26. Place of Dea	ath (Check only one)	
1 Yes 2 ¶	* 6	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 □ DOA	Other: 4 Nursing H	lome 5 Residence 6	Other (Specify)
27. Manner of Deat 1 ✓ Natural 2 ☐ Accident	h 5	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c.	Injury at Work? 1 □Yes 2 □No	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, off	fice	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	nysician: To the best of my knowledge, death niner: On the basis of examination and/or inve	occurred at ti estigation, in	he time, date and place my opinion, death occi	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)

29c. License number

D47451

29d. Date signed (Month, Day, Year) September 23,2009

washington county, 747 Northern Avenue

Hagerstown, Maryland 21742

State Registrar

Cynthia Kuther-Sandy mo

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

SEP 24 2009

Cynthia Kuttner-Sands MD Hospice of

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7:15A M Philip 2009 George Honsinger 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Salisbur the Wicomico 14050,CE 97 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours Min **XX**M 2□ F Yrs. 82 18,1926 MI 382-28-5852 Nov. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21811 18 Robinhood Trail 12. Was Decedent Ever in U.S. Armed Forces? ¥24yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Plant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Philip Honsinger Fannie Russell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Honsinger / Wife 18 Robinhood Trail, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Sept. Frankford, DE Cape Henlopen Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 Williams St., Berlin, MD. 21811 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARREDOVAS CULAR CCIDEN disease or condition resulting in death) Due to (or as a consequence of) SB12unR Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) □IJnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□N0 24a. Was an autopsy 1 □Yes SENO 25. Was case referred to medical examiner? 26. Place of Death (Check only on) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10521CR 1 ☐ Yes 2 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

<u>م</u>

Completed

Be ပ MD

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Marked Expressed on the instance of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending Physician:

400 Singly

burial-transi and attending physician as the for

signed by the a nis certificate has been s director, page 2 should l After this funeral

Examiner Physician/Medical þ Completed Be ဥ Certification: death. 24 hours after death e Funeral Director: completely filled in by the

BA 9+1

within 2

State Registrar

Medical

27. Manner of Death 5 ☐ Pending investigation _1#Natural 2 ☐ Accident 3 ☐ Suicide

29a. Certifier

4 🗌 Homicide

6 Could not be determined

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2/80-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

atturan 31. Date filed (Month, Day, Year) SEP 2 2 2009

29b. Signature and title of pertifier

10 150 P 32. Registrar's Signature

			1- State of Maryland / Dep. Registrar Ce	artment of Health and l rtificate of Death	Mental Hygier	0000	2102
	Physici		1. Decedent's Name (First, Middle, Last) Calvin Henderson		2. Date of Death Sept. 6,		3. Time of Death 1736 _M
	/Medio		4a. Facility Name (If not institution give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park	h	4c. County of Death Montgom	
	Funeral Director		5. Social Security Number 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Pay, Yes	ar) 9. Birth Cou	place (State or Foreign ntry)
	ne Maryland 8a-f show	ector		sville			10d. Inside City Limits 1 ☐ Yes 2 💆 No
	th with the 23a or 2 list be no	Funeral Director	5104 59th Avenue	10f. Zip Code 20781	10g.	Citizen of What Cou	ntry?
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Modical Evanting rust be notified at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married of Ityes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □Yes 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Bla	etc.
21215-0036	ithin 72 h ne. nan "natu	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking 16b	Financ	•
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Vital	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 Xes Yes 2 Xes Yes Other:	ath (Check only one)			
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Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S.	t and Number or Rui tate)	ral Route Number,
	e Hospital or 124 hours afte e Funeral Dir letely filled in	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place exestigation, in my opinion, death occurred	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the I	Me	29b. Signature and title of certifier Diry attending physicia	29c. License number MD 0 6 6 6 9	4 6 29d.	Date signed (Month	, Day, Year)
	>		30. Name and address of person who completed cause of death (Item 23a) (Type, Ping Li. 440 4 Queens hury Ro	m MD00669 Print) Ri Vordale	M 12 2	0737	/
	Sta Registr		31. Date filed (Month, Day, Year) SEP 23 2009	N.J.	11.017		

					artment of Health and	d Mental Hygi	iene	
			1 - State Registrar	Cei	rtificate of Death		eg. No. 9 1 0	91991
п	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Deatl Month	Day Year	3:-Time of Death
AS.	/Medi			er, III			r 22, 2009	3:25 a ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 9504 W. Stanhope Road		4b. City, Town, or Location of De	eath	4c. County of Death Montgome	
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	pu ,		Usual Residence of Decedent					
	aryla show	<u> </u>	10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2X No
	the M 28a-f	ectc	Maryland Montgomery 10e. Street and Number	Kensingto	on 10f. Zip Code	140	ng. Citizen of What Cou	
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	To the Hos within 24 ho To the Fur completely	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month	, Day, Year)
	5) Jan Jan		D0044157	S	eptember 2	2, 2009
	, -		30. Name and address of person who completed cause of de	ath (Item 23a) (Type,	Print)			
			Ira Berger, M.D., 1201 Seve	-l- 0:		MD 20854		
	Sta Registr	_	SEP 23 2009 SEP 23 2009	r's Signature	Ked.			

09-07557 Jessica Hannin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 01991

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Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	y Year	3. Time of Death
edical Examir	ner	Jessica Rene Hannin		Month Day September 28		0650 hrs
		4a: I dollity I dallo (Il flot illottation) g	Town, or Location of Death		4c. County of Death Prince George	
		9608 Tuckerman Street Lanh				
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	er 1 Year If Under 24Hrs. ns Days Hours Min.	7	M/DD/YYYY) 9. Bir Foreig	an I
Director	1	219-25-8815 1 M 2 XF 28 Yrs. World	is Days Flours	June 21,	, 1981 co	untry)Texas
		Usual Residence of Decedent				10d. Inside City Limits
any	- 1	10a. State 10b. County 10c. City, Town or Location				1 Yes 2 X No
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Ore ges 1 t of F		1 X Burial 2 Cremation 3 Removal from State crematory or other place		3/2009	Wincheste	r, VA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- li				vans Fune	
Bal Berm Depa Impo	-	Julkiel 16000	Annapolis Ro	ad Bowie,	MD 20715	rar nome
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode	e of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line.	nmental abno:	rmality o	f the	Death
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Box 687 e death certific the attending p	sic	1 Yes 2 No 9 ✓ Unknown Pregnant at time of death 5 Other (S)	Decity)			
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Division of Vital Records, tal or Attending Physician: The law require as after death. Director: After this certificate has been is led in by the funeral director, page 2 should I	$\bar{\Im}$	CC Management of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t	26.Place of Death (Chec			
ital ician: s certi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3	O#:		esidence 6 🗸 Ot	her: Scene
FV Phys er thi	ပို	1 V Yes 2 No 27 Manner of Death 28a, Date of Injury 28b, Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	
n of Niding Ph	 0	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
Sior Attend r death ector: by the	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, fact	ory, office building, etc.			Rural Route Number, City
Oivi al or al Dir ed in	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	ate)	
lospit t hour uners		798 Centrer m	the time, date and place, a	nd due to the cause	(s) and manner as s	tated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurred	d at the time, date a	nd place, and due to	the cause(s)
To Wit	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		hy hu, us	O.C.M.E.		September 29	, 2009
		30. Name and address of person who completed cause of death (Item 23a)				
TAD		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 21201			
	state					
Regi	stra					
DHMH 17 Rev 1.	2001	ORIGINAL		(CME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department		Mental Hy	giene		
			1 - State Certificate	of Death	_	Reg. No.		3 , 9 9
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea	Day	Year	3. Time of Death
	/Medic		Neil Dean Haldeman		00	1192	009	1025 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, To	wn, or Location of Deat	h	4c. County	of Death	2
			Coastal Hospice at the Lake Sal	Isbury			Cor	
	Funeral		5. Social Security Number 165–28–2639 1 🖫 M 2 🗆 F 77 7. Age (In yrs. last birthday) If Under 1 Months C	Year If Under 24 Hrs Days Hours Min.	8. Date of Birt (Month Da 03/15/	h 4 635	9. Birthp	place (State or Foreign Diry) Sylvania
	Director		165-28-2639 104 M 2 77 Yrs. Wrs. Vsual Residence of Decedent		03/13/	1932	Penn	isyrvailta
	and		10a. State 10b. County 10c. City, Town or Location				10	0d. Inside City Limits
	/aryl	ō	Maryland Wicomico Salisbury					1 □Yes 2X No
	28a-	Director	Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Co	ode		10g. Citizen of	What Coun	ntrv?
	with a or			21804		USA		,
	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or ttems 23a or 28a-f show event, the Medical Evarinar runt be notified at	Funeral			Specify Yes or No		ce - Americ	can Indian.
· ^	fter d	F	Armed Forces? If Yes, specify 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	nt of Hispanic Origin? (5 Cuban, Mexican, Puer	to Rican, etc.)	Bla	ck, White, e	
3	al", o	þ	1 □ Never Married 2 ☑ Married 1 □ □ Yes 2 □ No If Yes, Give 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Yes 2 ☑ 1 □ Y	No Specify:		Specif	/: wh	nite
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215	hin 7.	e D	(Specify only highest grade completed) (Give kind of work of life. DO NOT use if sementary/Secondary (0-12) College (1-4or 5+)	done during most of wo retired)	rking			
21	d with giene	o.	12 5+ educator			educat	ion	
g	al Hygid	Be (17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle,	Maiden Surnar	<i>1е)</i>	
Maryland	should be fi and Mental I is marked of aumatic ever	To	Elbert W. Haldeman	Mabel	King			
aĽ	and I		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (S			-		Code)
	1 and 2 Health a tem 27 is		Joan Haldeman/spouse 801 Long	Warf Rd.,	Salisbur	y, MD 2	1804	
S.	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Wedfell Examinational Do notified at		20a. Method of Disposition 20b. Place of Disposition (Name cemetery, crematory or other	of er place)	Date	20c. Location	· City or To	wn, State
Ĕ	Pages nent of ant: If Its ary or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify Component) **Completely crematory or other Wicomic Memor Park**	ial 9/2	26/09	Salisk	oury,	MD
Baltimore,	permit. Pages 1 and De artment of Heal Important: If Item 2 and injury or other 2002.		LITCOMORGIA	Address of Facility al	Home Pro	ofessio	nal A	ssociation
m	8 3 E 8 8		avid of homes CFSP 501 Sn	ow Hill Rd	., Salis	oury, M	218	04
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause	of dying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Causities	arcin.	an is			Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	a cere		Mary.		7200
	Examiner	6 V					- 4	ď.,
	T 4	ner	Sequentially list conditions, if any leading to instruct the cause. Enter Underlying					
	cuter od ransi	Examiner	Cause (Disease or injury that initiated events c.					
oʻ	e exe an al rial-t		resulting in death) Last Due to (or as a consequence of):					
8760,	ficate be executed physician and s the burial-transit	dical	d				110	
	ng ph as tl	Jed	IF FEMALE:					
P.O. Box	eath certific attending p	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	anancv		1 .	ate of delive	
	e dea	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (spec			IV	onth	Day Year
٦.	at the ded by the stached	Ph.	9 🗆 Unknown		00. 10/4		Authorite to Al	har annua of dooth?
Ś	iires that signed b d be deta	ğ	Part II. Other significent conditions contributing to death but not resulting in the underlying cause	se given in Part I.				he cause of death?
5	w requir been s should	ted	una paresanon		101	Yes 2 No	3 Proc	bably 4 Unknown
ပို	law ras b	ble			24a. Was autor	osy	Were auto	ppsy findings availeble empletion of cause of
r	: The I	Completed			perfo	rmed?	death? 1 □ Yes	
<u>=</u>	nysiclan: nis certific director, I	Be (25. Was case referred to medical examiner?	T	ath (Check only o	ne)		
>	Physic this or al dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 \(\sum \) Nursing	Home 5 ☐ Resi	dence 6 🗖 🖰 t	ner (Specif	(y) Hospice
C	ding P h. After t funera	ü	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c. Time of Injury 28c.	. Injury at Work?	28d. Describe	how injury occur	red	
Division of Vital Records,	tendi leath. tor: A the fu	ati	2 Accident investigation M	1 ☐ Yes 2 ☐ No				
Ë	irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffice	28f. Location (: City or To	Street and Num vn, State)	ber or Rura	al Route Number,
2	spital or ours afte leral Dir filled in							EAST-CO.
	Hosp 4 hot Fune ely fi	ical	29a. Certifier (Check only Check only C					
	To the Hospital or Attending Physician: The law requires that the death certific To the Law requires that the death certificate has been signed by the attending I completely filled in by the funeral director. After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) and manner stated.	icense number	· · · · · · · · · · · · · · · · · · ·			
	P = P = P	~				29d. Date signe		
	Etly			29505		w 7 -	17	. 2009
	1757	. 1	10. Name and ordress of person who completed cause of death (Item 23a) (Type, Print)	LIMADO	a estate and i	1.00.	ناه ا مارد	A D . C
	-01		GREGORIO M. BELLOSO, M.P. 5302 CH 31. Date filed (Month, Day, Year) 32. Registrar's Signature	TINALERRY	VR, SA	LISBUR	, ×, ~	טעוג עו
	Sta Registr		SFP 22 2009 June S. Sall					
	- 3		Loud persons 19. 20 acres					

DHMH 17 Rev 1/2001

Neil Haldeman

			For	State of Maryla					Mental Hy	/gien	e	
			1 - State Registrar		C	ertifica	te of L	Death		Reg. N	lo. 9 ()	31993
	Physici /Medic		1. Decedent's Name (First, Middle, Las Raymond Russ						2. Date of D	D	ay Year 700	
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City	, Town, or	Location of Deat	h	4	c. County of Dea	
				oice at 41	re Lak	2 <	sali	Soun	1			2mico
- 1	Funeral Director		5. Social Security Number 217–10–3679 6. §	ex 7. Age (In yi	rs. <i>last birthda</i> Yrs.	Months	er 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D 04/03)	7191	9. Bi	rthplace (State or Foreign ountry) ryland
	pug 🔉		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or	Logation						10d. Inside City Limits
	larylar F shov	ō	Maryland Wicomi		Salisbu							1 ☐ Yes 2 ☑ No
	the N	Director	10e. Street and Number	.00			ip Code			10a. C	Citizen of What C	ountry?
	death with the Maryland ms 23a or 28a-f show must be rollfed at		4005 Meadowbridg	e Rd.			21804	4		_	SA	
2	tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1:	3. Was Dece If Yes, spe	edent of H	ispanic Origin? (S in, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - Am Black, Whi	
2-0036	urs afte al', or i	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐ Yes 2 MX No If Yes, Give Year or Dates:		1 □Yes	2 X o	Specify:			Consider	white
士 0-5	72 ho	eted	15. Decedent's Ed	lucation de completed)	16a. De	cedent's Usi	ual Occupa	ation during most of wo	rkina	16b.	Kind of Business	s/Industry
2121	vithin sne. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				furing most of wo	9	.	n	•
9	filed v Hygie ther i		17. Father's Name (First, Middle, Last)		I OWI	ner/op	eraco	18. Mother's Na	ne (First, Middle		nsurance	
) d	uld be Mental Irked o	To Be	Raymond A. Hitch						ce Pryo		σσασ,	
Mary,	nd 2 shou alth and N 27 is mar r traumat		19a. Informant's Name/Relationship (Stephen Hitch/so	**				and Number or R cidge Rd				
Raymond altimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macillant Examination and injury or other traumatic event, the Macillant Examination and once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dis cemetery, ci	Memo	other place	i	Date 1/09		Location - City of	
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Cicen	ine (FS)	Par	Hollo 501 S	and Address way F now H					association 804
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de								Approximate Interval Between
	Physician		immediate Cause (Final disease or condition	CHRONIC	OBST	RUCT	TUR	Palm	ONARY	7)15	RASB	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):							
		ē	Sequentielly list conditions, if any, leading to immediate	b. Due to (or as a conse		4						
	cuted	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.								
60,	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):							
68760,	ficate physi the b	edical		d								
Box (eath certific attending p for use as f	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg							23d. Date of de	alivery
0. B	death he atte	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		B ☐ Ectopic		/ :-			Month	Day Year
Ρ.Ο	nat the de d by the etached	Phy	9 Unknown			d d d		on in Donat I	00° Did			to the serve of death?
Division of Vital Records,	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ed by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying	cause give	en in Part I.			o use contribute t	to the cause of death? Probably 4 Onknown
Reco	he law r has be ge 2 sh	Completed							24a. Was		prior to	utopsy findings available completion of cause of
<u>ra</u>	siclan: The la certificate ha irector, page 2		25. Was case referred to medical						1 □ Yes	2 E K		
>	ysicla s cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2	☐ FR/Outpat	ient 3□D	OA Othe	26. Place of De	`		6. ØOther (Spe	miles Halling
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Sio	tendii eath. or: A the fu	catic	2 ☐ Accident investigation		, , , ,	М		Yes 2 □No				
Divi	al or Attend s after death Il Director; A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, s	street, factor	ry, office		28f. Location City or To			Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) Certifying Ph	ysicien: To the best of my k niner: On the basis of exami end manner stated.	nowledge, de ination and/or	ath occurred investigation	d at the tin	ne, date and plac pinion, death occ	e, and due to the urred at the time	e cause , date a	(s) and manner and place, and du	as stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29	c. License				ate signed (Mon	th, Day, Year)
	10						00	00584	'ce	6	1/17/0	5
	Las		30. Name and address of person who	1 00	4	e, Print)		eis Bu				2
	0	to	31. Date filed (Month, Day, Yagr) 2 2	32. Fegistrar's Sig	nature.	230	SA	eriju	1	ng	2/18	20
	Sta Registra	ar	SEP 2/2 2	009 Genera	B. 1	barke	1		f			

		State of Ma 1- State Registrar AMEND#23a-PI-1per MD, 9-23-			h and Mental Hy th	/ /	0 01		
		1. Decedent's Name (First, Middle, Last)	O9,EMM,MOSO	imodic or Boat	2. Date of De	Reg. No. 2. Date of Death 3. Time of Death			
Physic		Benjamin)01	N	Scoto-be	or 20 2009	0610 AM		
/Med Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location		4c. County of Deat			
		The Johns Hopkins Hospital		Baltimore City					
Funeral		5. Social Security Number 6. Sex 7. Age 1 M 2 F	(In yrs. last birthday) Yrs.	If Under 1 Year If Un Months Days Hou		ly, Year) Col	hplace (State or Foreign untry)		
Director		Usual Residence of Decedent	83		Septembe	r 25,1925	Florida		
aryland show	١.	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits		
e Mar 3a-f s	Director	Maryland Montgomery		Silve	er Spring		1 🕱 Yes 2 🗌 No		
ith th or 28	Dire	10e. Street and Number		10f. Zip-Code		10g. Citizen of What Co	untry?		
ath w s 23a ust b		14028 Crest Hill Lane			905		S.A.		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 🖫 Married 1 □ Yes 2 🐨 N If Yes, Give	0	Was Decedent of Hispanic f Yes, specify Cuban, Mex 1 ☐ Yes 2 X No Spec		14. Race - Ame Black, White Specify:	e, etc.		
21215-0036 d within 72 hours aft giene. er than "natural", or the Medical Exami	q pe	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education	16a Dece	dent's Usual Occupation		16b. Kind of Business	Asian		
15 in 72 in al	olete	(Specify only highest grade completed)	(Give	kind of work done during i DO NOT use retired)	most of working		, and a second		
d 212 filed with Hygiene. other than	Completed	Elementary/Secondary (0-12) College (1-4 or 5-1		Entrepreneur		Food	Store		
e filectal Hygothe othe	Be	17. Father's Name (First, Middle, Last)		18. M	lother's Name (First, Middle	e, Maiden Surname)			
arylano should be nd Mental I marked o	2	Jew On			Jear Yuk	Kim			
Maryland d 2 should be file th and Mental Hy ?7 is marked oth traumatic event.		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Nu	ımber or Rural Route Numb	per, City or Town, State, 2	Zip Code)		
e, M 1 and 2 Health tem 27 i		Clayton O. Jew - Son			Farm Drive, Spe		,		
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crer	natory or other place)	Date	20c. Location - City or			
ti Pa t. Pa ntmen ntant:		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee MO #1070 _		eaven Cemetery 2. Name and Address of Fa	09/28/2009	Silver Spri	ng, Maryland		
Baltimo permit. Page Department of Important: If any injury or once.		Namey A. Kercen	Tue 1	ines-Rinaldi Fu 1800 New Hampsh	uneral Home, Inc hire Avenue, Sil	ver Spring, Ma	aryland 20904		
		23a. Part 1. Enter the disease, or complications that caused to shock, or heart falure. List only one cause on each line	the death. Do not ent	er the mode of dying, such	h as cardiac or respiratory a sease Syndron	arrest,	Approximate Interval Between		
Physician		Immediat use (Final diseas or condition	5/ Seps	is .	sease synaron		Onset and Death		
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LAGITATION	<u></u>	Sequentially list conditions, b.	monia		٠				
A po ts	ij	rrary, leading to immediate cause. Enter Underlying Cause (Disease or injury	Proumon i	eumonia					
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Box death cer attendin	icia	1 Ves 2 No 4 Pregnant at t	2 Fetal death 3 time of death 5	Other (specify)		Month	Day Year .		
t the c	اپر م	9 ☐ Unknown 9 ☐ Unknown					•		
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certific director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death bu	it not resulting in the u	underlying cause given in I	Part I. 23e. Did	tobacco use contribute to Yes 2XNo 3 □ Pr	o the cause of death?		
col v req been shou	Completed		•		24a. Was		topsy findings available		
Rec he law e has t	l mo				auto perfo 1 ∐ Yes	psy prmed? death? 2 No 1 ☐ Yes	completion of cause of		
ital an: T ifficate tor, p	a)	25. Was case referred to medical		· 26. P	lace of Death (Check only o				
ystcia ystcia ys cert	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpatien	t 3 DOA Other: 4	Nursing Home 5 Resi	dence 6 Other (Spe	cify)		
D O O O O O O O O O O O O O O O O O O O		27. Manner of Death 28a. Date of Injury 1 ✓ Natural 5 ☐ Pending (Month, Day		f 28c. Injury at Work?	28d. Describe	how injury occurred			
SiO endin sath. or: Aff	atic	2 Accident investigation		M 1 ☐ Yes 2	2 No				
ivecton by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injur building, etc.	ry - At home, farm, str (<i>Sp</i> ec <i>ify)</i>	eet, factory, office	28f. Location Cify or Tov	(Street and Number or R wn, State)	ural Route Number,		
ital of urs af ral Di	ပီ	29a, Certifier 1 🔏 Certifying Physician: To the best of	my knowledge, death	a coourred at the time, dat	o and place and due to the	and manage	o atata d		
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page	Medical	29a. Certifier (check only one) A Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or in						
To the	Me	29b. Signature and title of certifier		29c. License numb	per	29d. Date signed (Mont	h, Day, Year)		
is		Stew Pre		Res-	000	Septombur	20 2009		
		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,						
		Struc Puglicst	'e Signaturo		600 North Wo	olfe St, Baltimo	ore, MD, 21287		
Si Regis	tate trar	31. Date filed (Month, Day, Year) SEP 23 2009	2 /	Ked					

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	,	Certificate of L	Death	R	eg. No. 200	9 81995		
Physici		Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Yea	3. Time of Death		
/Medic		Patricia Anna John		Sept.			9:58 A.M			
4a. Facility Name (If not institution, give street and number) 3146 Gracefield Road #105				4b. City, Town, or Silver	Location of Death		4c. County of D			
Funoval	щ.	5. Social Security Number 6. Sex	7. Age (In yrs. last birtho		If Under 24 Hrs.	8. Date of Birth (Month, Day,	Prince 0	Birthplace (State or Foreign Country)		
Funeral Director		045–30–6060 1	74 Yrs	Months Days	Hours Min.	(Month, Day, Nov. 29		country) ew Jersey		
land ow		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits		
Maryl F sho	ţ	MD Prince Georges	s Silver	Spring				1 ☐ Yes 2 📉 No		
h the or 28a	irec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?		
th wit	la L	3146 Gracefield Road #	105	20904		τ	Jnited Sta	ates		
tems	Funeral Director	Armed I	cedent Ever in U.S. Forces?	 Was Decedent of Hi If Yes, specify Cuba 	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ☐ Widowed 4 ☐ Divorced Year or	2 No Bive Dates:	1 ☐ Yes 2 🙀 No	Specify:		Specify: W	nite		
72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed	16a. D	ecedent's Usual Occupa Give kind of work done of ife. DO NOT use retired	ation Juring most of work	ing	16b. Kind of Busine	ss/Industry		
within sne.	g l		(1-40r 5+)	ife. DO NOT use retired Nemaker)		Own Home			
filed / Hygid		17. Father's Name (First, Middle, Last)	<u> </u>		18. Mother's Name	e (First, Middle, I				
ld be lental ked c	To Be	George Francis Craig			Mary Fra	inces Shi	irkey			
an y shou and N s mar	-	19a. Informant's Name/Relationship (Type. Print)	19b, M	Address (Street a	and Number or Rur	al Route Number	, City or Town, Stat	e, Zíp Code)		
and 2 and 2 ealth n 27 i		William L. Johnston/Hus	S_{11}	lver Spring	MD 2090	14				
ges 1 t of H if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fror	20b. Place of D cemetery,	isposition (Name of crematory or other plac	Sept	∙ 21 ⊥	20c. Location - City			
t. Pag rtmen rtant:		4 Donation 5 ☐ Other (Specify)	1 (() () () ()	own Univer Center	SIIV	_ 11/	Vashingto	ervices,P.A.		
Deparmi Depara Impo		21. Signature of Funeral Service Licensee		9013 Annapo	olis Rd.,	umbia Mo. Lanham,	ortuary Se , MD 2070	ervices,P.A.		
		23a. Part 1. Enter the disease, or complications that caused the d., th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Physician		Immediate Cause (Final disease or condition	Horti	c Sten	0515			Onset and Death		
/Medical Examiner		resulting in death) Due t	o (or as a consequence of)							
- A	Ē	Sequentially list conditions, if any, leading to immediate b.								
uted	Examiner	cause. Enter Underlying Cause (Disease or injury	,							
an an rial-tra	Exa	that initiated events c								
The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Medical	d								
ertifica ling pl	Med	IF FEMALE:								
eath ce attendi	ian/	23b. Was decedent pregnant 23c. If yes, o	23d. Date of Month	23d. Date of delivery Month Day Year						
at the de by the a	Physician/	1								
that that ined by detail		Part II. Other significant conditions contributing to	bacco use contribut	cco use contribute to the cause of death?						
quires en sign uld be	d by	1 □ Yes						2 ➡️No 3 ☐ Probably 4 ☐ Unknown		
law requir as been s 2 should	Completed					24a. Was a	n 24b. Were	autopsy findings available		
The lacate has	mo;					autops perform 1 ☐ Yes	ned2 deatl	to completion of cause of n? Yes 2.☑No		
Attending Physician: The death. ector: Affer this certificate by the funeral director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Deat					
Physic Physic rthis or	ပ္	1 Yes 2 No Hospital: 1 □	Inpatient 2 ER/Outp		4 LI Nursing Ho		ence 6 Other (S	Specify)		
ding F h. After funera	Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28b. Injury at Work?								
Attendi death. ctor: A y the fu	licat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number)								
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Hospital or Attend 24 hours after death Funeral Director: etely filled in by the	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the and me	basis of examination and/	death occurred at the tir or investigation, in my o	ne, date and place pinion, death occur	and due to the or	ause(s) and manne late and place, and	er as stated. due to the cause(s)		
To the Hosp within 24 ho To the Fune completely f	Mec	29b. Signature and title of certifier	anner stated.	29c. License	e number	2	9d. Date signed (M	onth, Day, Year)		
F S F O		Andrew fluidet 10037/6 So 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Handrew Kundah M. J. 3110 Grace Fild Rd								
1		30. Name and address of perspn who completed ca	use of death (Item 23a) (Ty	/pe, Print)		//	J. J. W. Po.	1 1		
2		Hadren Kundia	Med,	3110 61	acetil	1 Kd	5:/00	1 Janas Kut		
	ito	31. Date filed (Month, Day, Year) 32.	Registrar's Signature					, -,		

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND#8 PER FH. **1 -** State Registrar9/21/09 AACO HEALTH DEPT. CMH Certificate of Death 1. Decement's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2105 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 24 Lincoln Anne Parkway Annabolis Arundel | Tunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 4 Ay 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🗹 F Maryland 1913 213-22-2360 96 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Ire Medical Exx. in at must be rediffed at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 ☐ Yes 2 No Annapolis Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 Lincoln Parkway 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Completed by Specify: Black 3√ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Sales G.C. Murphy Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floe Florence Chase Richard Woodard ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence E. Day(Daughter) 24 Lincoln Parkway Annapolis, Md. 21401 20a. Method of Disposition 20b. | | Place of Disposition (Name of Cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 9-21-09 Annapolis, Md. 4 □ Donation 5 □ Other (Specify) Time Reports of Compons Mortuary, P.A.

Annabolis, Md. 21401 21. Signature of Funeral Service Licensee Jarry D. Rees Mc 0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 us disease or condition resulting in death) /Medical Due to (or as pronsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 1 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? his certificate his I director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 →No Hospital: After this c funeral dire Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d_Date signed (Month, Day, Year) 30 Name and address of person ted cause of death (Item 23a) (Type Print)

State Registrar 11CHAE

31. Date filed (Month, Day, Year)

M

32. Registrar's Signature

ANNAPOLIS MD21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1145M Robert Leslie Kohler Medical 20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 8. Date of Birth
(Month, Day, Yea
May 23, 1 9. Birthplace (State or Foreign Days Hours Min Months Director 579-38-6964 Washington D.C Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Washington <u>Hagerstown</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funera! 10828 Coffman Ave 21740 U.S.A. death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, med Forces Black, White, etc. 1 Never Married 2 Married Ď 1 Yes 2 If Yes, Give Year or Dates 72 hours after Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 XNo Specify. "natural", 3 🗌 Widowed 4 🗀 Divorced Completed Specify: White mit. Page 1 and 2 should be filed within 72 hours partment of Health and Mental Hygiene. obriant; If item 27 is marked other than "natur injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Eletrical Engineer</u> Utilities Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frderick Kohler Nora Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Kohler / Wife 10828 Coffman Ave. Hagerstown Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important; If ite
any injury or ot 20c. Location - City or Town, State 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Haven Cemetery 9/25/2009 Hagerstown, Maryland Funeral Service Li 21. Sign dre 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave. Hagerstown Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRANN MERSTATIC Physician/ disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of): Examiner 2-3 DAYS EUMONIA Sequentially list out offices if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami requires that the death certificate be executed ARDIOR ARRYTHM 1AR MONTHS. that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Yes the g 9 Unknown Unknown P.O. I ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. per 23e. Did tobacco use contribute to the cause of death? signe ' be a Completed by Records, 1 ☐ Yes 2 ☐ No 3 Ø Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has by page 2 s autopsy Hospital or Attending Physician: The perform certificate 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Division of Vital director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🎾 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 🔀 Natural 5 Pending in 24 hours after death.

The Funeral Director: After the funeral in the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of the funeral control of 1 🔲 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DADIR

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1190

Registrar's Signatur

29c. License number

AETWA

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ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^Dลื้7 2<u>00</u>ั้9 **Physician** 11:12 A M September Eleanor Marie Kaufmann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Williamsport Homewood Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)an. 4, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Months Days Hours Min. Washington, D.C. Jan. Director 82 577-30-7400 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar mart by notified at 1 ☐ Yes 🖈 No Director Williamsport <u> Maryland Washington</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21795 16505 Virginia Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐧 No 14. Race - American Indian. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White \$ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Charles County 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Key Punch Operator 12 Community College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ George W. Gibson Elizabeth Belle Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a permit. Pages 1 and:
Department of Health
Important: If item 27 i
any injury or other tra 263 New Way Dr. Shepherds Town, West Virginia 25443 <u>Judith M. Sager/ Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 23, 2009 Bryantown, MD. 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 21. Signature of Funeral Service Licensee Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. moize4 23a. Part 1. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final **Physician** SCHOTTI MENIO disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trans Due to (or as a consequence of) physician street Records, P.O. Box 68760, Physician/Medical / the attending pt IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? ontributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Haknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has this certificate 1 □Yes 2 □W Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 HV0 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation thin 24 hours after death.

the Funeral Director: A simpletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Signs 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

BB5

ompleted

Day,

2 2 2009

cause of death (Item 23a

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month James Krall John 09 2009 4c. County of Death, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hianies MosicaL REGIONAL CENTE TENIN SULA 316/3541 If Under 1 Year | If Under 24 Ars. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Social Security Number Date of Birth (Month, Day, Year) Days Hours 175-32-0209 1 X M 2 □ F Months 05/26/1944 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21804 USA 5868 Kirknewton Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government F.B.I. Special Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Elko John Krall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5868 Kirknewton Dr., Salisbury, MD 21804 Regina Krall/spouse 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/18/09 Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition mur disease or condition resulting in death) Due to (or as consequence of): or sho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as sconsequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 DNO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

executed

The law requires that the death certificate be

P.O. Box 68760,

Division of Vital Records,

Department of Health a Important: If item 27 Is any Injury or other tra

Physician

/Medical

Examiner

Funeral

Director

show

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Director

Funeral

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Completed

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traumatic event, the Medical Exeminer hust be notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Items 23a or

Baltimore, Maryland 21215-0036

the Maryland

and burial-trar attending physician for use as the buria ate has been signed by the page 2 should be detached

Examiner Physician/Medical certificate Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica etely filled in by the funeral director, p

9 Unknown

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Medical

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State

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier

ECARROLL ST

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Registrar

			For State Registrar	e of Marylan		rtment of F tificate of I		/lental Hy	giene Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year_	3. Time of Death
	/Medi		Ruth Loewenstein		Septe			per 1	7 , 2009	5:55 p м	
1	Examir	ner	4a. Facility Name (If not institution, give street and				Location of Death			County of Death	
and the			Montgomery General Hos			Olney	If Under 04 Ure	T		ontgomer	•
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug. 3	th a <i>y, Year)</i> 0, 19	16 New	place (State or Foreign ntry) Jersey
Maryland 21215-0036	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation				1	0d. Inside City Limits
	a-fs	ctor	Maryland Montgomery	Bro	okevi1	.1e					1 ☐ Yes 2 🖾 No
	tth with the 23a or 28 ust be not)ire	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Coun	itry?
		ral	1127 Hawlings Road			20833			Unite	ed State	.S
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanting must be notified at	Completed by Funeral Director	1 Never Married 2 Married 1 Yes	Decedent Ever in U.\$ d Forces? es 2⊠No , Give or Dates:		Vas Decedent of H Yes, specify Cuba □Yes 2🏿 No	ispanic Origin? (Sp an, Mexican, Puerto <i>Sp</i> ec <i>ify:</i>	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, e Specify: Wh	
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Ž	2 should be f and Mental is is marked of raumatic eve	မ	Max A. Shapiro		T						
Na Na	d2sl than 7 is 1		19a. Informant's Name/Relationship (Type. Print)				and Number or Rui				(Code)
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Baltimo	permit. Pages Department of I Important: If ite any Injury or or once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify)	om State Ft.	Linco		tory 9/23	/09	Brent	twood, M	
			21. Signature of Funeral Service Licensee				ss of Facility Sin				852
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σ.	that ned b deta	/ Ph	Part II. Other significant conditions contributing		ulting in the un	derlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to the	he cause of death?
ds	thin 24 hours after death. • the Funeral Director: After this certificate has been signed by the attending properties of the funeral director. After this certificate has been signed by the attending properties of the funeral director, page 2 should be detached for use	q p	Hypertensio	n				1 🗆	Yes 2 🗹	No 3□ Prob	pably 4 Unknown
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Division of Vital Records,	death. ctor: A	atic	2 Accident investigation M 1 Yes 2 No								
	ai or Att s after d al Direct ed in by	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	lace of Injury - At ho uilding, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rura	al Route Number,
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On t and	o the best of my know he basis of examinat manner stated.	wledge, death tion and/or inv	occurred at the til restigation, in my o	ne, date and place pinion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as s place, and due to	stated. the cause(s)
		W	29b. Signature and title of certifier Auch Broze	ush	mo	29c. Licens	e number . 5956			e signed (Month,	Day, Year) 18, 2009
			30. Name and address of person who completed					075. 01	1		
-	Sta	te	Dawn Asano Broderick, 31. Date filed (Month, Day, Year)	M.D. 18 2. ▶egistrar's Signat		ince Phil	ip Dr. #	2/5; 01	ney,	MD 2083	
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